

**FFY 2014-2015 Mental Health and Substance Abuse Block Grant Application
DRAFT**

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Introduction

The Indiana Family and Social Services Administration, Division of Mental Health and Addiction is pleased to present this combined Substance Abuse and Mental Health Block Grant application for 2014-2015.

The Division of Mental Health and Addiction is a division within an umbrella agency, Family and Social Services Administration, which includes the major social service agencies: Division of Disability and Rehabilitative Services; Division of Aging; Division of Family Resources; and the Office of Medicaid Policy and Planning. The co-location of these agencies greatly enhances the communication and interaction of these providers of services.

As was done two years ago, this document was prepared by many within this office. The combined efforts and the benefits of those efforts experienced two years ago were in evidence in this application as well. The plan developed two years ago also included an increased involvement of the planning council in their participation in the four priority area work groups. This has proven beneficial to both this office and to the planning council. That involvement of the planning council will continue. This document begins with an overview of the state system and includes the five criteria that are statutorily required for the Mental Health Block Grant application.

The Indiana combined application is dedicated this year to the memory of Craig Andler who was a therapist, advocate, and early proponent of integrated treatment for those with a co-occurring mental illness and substance use disorder.

Overview of the State

Criterion 1 – Established System of Care

Indiana has a statewide mental health and addiction recovery system that ensures treatment availability in all 92 counties through contracts with 25 community mental health centers and other specialty providers. In 90 counties, there is at least one satellite office of a community mental health center (CMHC). There is active outreach coupled with the provision of transportation to the nearest CMHC facility for services in the two counties without a satellite office. By practice, Indiana's measure of accessibility is that outpatient services are available in the county, an adjacent county or within a 60 minute drive. The State of Indiana funds administered by the Division of Mental Health and Addiction (DMHA) are utilized for individuals with a serious mental illness and/or a substance use disorder, and that are at or below 200% of poverty. This ensures that the limited funds are utilized by those most in need and least able to access mental health or addiction treatment services.

The CMHCs are required by Indiana Administrative Code and by contract to provide a defined continuum of care. Continuum of care means a range of services, the provision of which is assured by a community mental health center or contracted addiction provider. The term includes the following:

- Individualized treatment planning to increase patient coping skills and symptom management, which may include any combination of the services listed under this section
- Twenty-four (24) hour a day crisis intervention
- Case management to fulfill individual patient needs, including assertive case management when indicated
- Outpatient services, including intensive outpatient services, substance abuse services, and treatment
- Acute stabilization services including detoxification services
- Residential services
- Day treatment, partial hospitalization, or psychosocial rehabilitation
- Family support
- Medication evaluation and monitoring
- Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty

The Division of Mental Health and Addiction is in the process of redefining the continuum of care that will define safety net services as well.

Description and Definition of the Case Management System

Case Management consists of services that help consumers gain access to needed medical, social, educational, and other services. This includes direct assistance in gaining access to services, coordination of care, oversight of the entire case, and linkage to appropriate services. Case Management does not include direct delivery of medical, clinical, or other direct services. Case Management is on behalf of the consumer, not to the consumer, and is management of the case, not the consumer.

Health, Mental Health, Addiction, and Rehabilitation Services

Indiana supports and encourages the use of evidence-based practices (EBPs). For the past two years the Division has funded a wide range of evidence based practices including Assertive Community Treatment, Illness Management and Recovery, Supported Employment, and Supportive Housing.

In keeping with DMHA's movement towards a recovery-oriented system of care, the DMHA Office of Consumer and Family Affairs issued a request for proposals in 2009 for Recovery Specialist training and certification. A contract was completed with Affiliated Service Providers of Indiana to provide the training, certification testing, and provision of continuing education guidelines and marketing activities related to the program. The services of a Certified Recovery Specialist are eligible for Medicaid reimbursement. While many providers have hired Certified Recovery Specialists, not all have, and DMHA is encouraging 100% participation.

Employment Services

Indiana recognizes the importance of employment in achieving recovery. DMHA, in conjunction with the Office of Vocational Rehabilitation Services (VRS) established a series of Supported Employment (SE) establishment grants that were instrumental in furthering SE in the state. All CMHCs have supported employment programs with the exception of two, and those have working relationships with local VRS offices. To promote positive outcomes, improvement in consumer employment is one of the performance measures by which providers earn payment incentives.

Housing Services

The CMHCs provide a range of residential services but safe, affordable, independent housing is not readily available for all consumers served in the public behavioral health system. Therefore, DMHA has determined that development of a statewide housing plan will continue to be one of its priority areas. The Indiana Housing and Community Development Authority, in conjunction with the Corporation for Supportive Housing, has provided a series of Supportive Housing Institutes. The institutes are designed to help providers establish new and innovative relationships with local funders of housing and local providers of housing, with the intention of establishing a new dynamic in housing in which the treatment provider focuses on treatment and the housing provider focuses on housing.

Addiction Services

The Division of Mental Health and Addiction (DMHA) funds 25 community mental health centers (CMHCs) in Indiana which provide mental health and addiction services, either directly or by subcontract. In addition, there are four DMHA-funded specialty addiction treatment providers and seven other subcontracted specialty addiction providers. Most CMHCs and specialty addiction providers are also endorsed providers for gambling addiction treatment. Indiana received an Access to Recovery (ATR) grant from SAMHSA in 2007 and again in 2010 to develop and maintain a recovery-oriented network of additional faith and community-based providers in eleven of Indiana's largest counties, as well as all service members and veterans statewide. ATR may serve as a model for expansion of treatment and recovery support alternatives throughout Indiana in the future. Another SAMHSA grant awarded for 2011 to 2015 is for Screening, Brief Intervention and Referral to Treatment (SBIRT) to expand addiction screening into primary health settings. Finally, SAMHSA awarded DMHA the Cooperative Agreement for State Adolescent Treatment Enhancement and Dissemination (SAT - ED) in 2012 to expand evidence-based treatment to youth with substance-related and co-occurring disorders throughout Indiana by 2015.

Recovery Support Services

All funded providers offer a wide array of recovery support services. Those services will be enhanced by the individuals that are being trained and certified as Certified Recovery Specialists. Recovery supports remains one of the four priority areas for this Block Grant application.

Services for Persons with Co-occurring Substance Use and Mental Health Disorders

The community mental health centers in Indiana have services for both mental illness and addictions. Many have combined those and offer Integrated Dual Disorders Treatment.

Other Activities Leading to Reduction of Hospitalization

Since the closure of one of the larger state hospitals, Indiana has continued to reduce the number of state operated beds. Each community mental health center is allocated a number of beds. Utilization of state-operated beds has consistently decreased, therefore, the Division of Mental Health and Addiction has steadily reduced the number of state-operated beds. The community providers have provided more intensive case management and other evidence based practices to better serve individuals in the community instead of hospitalization.

Medical and Dental Services

Integration of primary health care is one of the priority areas identified in this year's state plan. While all providers complete health screening, we are confident that better linkage and communication and coordination between our system of care and the primary health providers

can be accomplished. CMHCs are required by rule to complete a physical health screening with referral for a physical examination when clinically indicated. For residential care, the administrative rule states that the provider must assist the resident to obtain medical and dental care.

State Hospitals

Indiana operates five hospitals for adults with serious mental illness and persons committed to the hospitals through the criminal justice system. All of the hospitals have attained accreditation under the Joint Commission. For the past two years, DMHA has awarded grants to increase community-based services necessary to reduce need for hospitalization. We have instituted a gatekeeper model whereby a community mental health center placing an individual in a state operated facility must continue an active, on-going relationship with the consumer, including treatment planning and discharge planning for that individual.

Criterion 2: Estimations of Prevalence

State Definition of Serious Mental Illness

Indiana Administrative Code (440 IAC 8-2-2) provides the definition of adults with serious mental illness (SMI) as follows:

1. The individual is eighteen (18) years of age or older.
2. The individual has a mental illness diagnosed under the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association.
3. The individual experiences significant functional impairment in two (2) of the following areas:
 - Activities of daily living
 - Interpersonal functioning
 - Concentration, persistence, and pace
 - Adaptation to change
4. The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, adults who have experienced a situational trauma do not have to meet the durational requirement of this clause.

This definition closely parallels the federal definition of serious mental illness and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

Estimation of Prevalence of Serious Mental Illness

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of adults with SMI in Indiana. The first method is calculated using the Center for Mental Health Services methodology. The second method is based on the priority population eligibility requirement which, in addition to the definition for SMI above, includes eligibility at or below 200% of the federal poverty guidelines. The prevalence estimates for Indiana adults with SMI are depicted in the following table.

**Indiana Adults with Serious Mental Illness
2011 Population Estimates**

Eligible for DMHA Services (at or below 200% of FPL)	103,601
CMHS Estimation Methodology	265,643
2010 Indiana Population aged 18 and above	4,919,319

State Definition of Serious Emotional Disturbance

In Indiana, the Division of Mental Health and Addiction considers children to encompass birth through 17 years of age. The implemented definition of serious emotional disturbance (SED) is as follows:

1. The child has a mental illness diagnosis under DSM-IV.
2. The child experiences significant functional impairments in at least one of the following areas:
 - Activities of daily living,
 - Interpersonal functioning,
 - Concentration, persistence and pace,
 - Adaptation to change
3. The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, children who have experienced a situational trauma, and who are receiving services in two or more community agencies, do not have to meet the duration requirement of this clause.

This definition closely parallels the federal definition of serious emotional disturbance and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

Description of Estimation Methodology for Serious Emotional Disturbance

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of children with SED in Indiana. The first method is calculated using the Center for Mental Health Services methodology, which pertains to youth, aged 9 through 17 only. The second method is based on the priority population eligibility requirement which, in addition to

the definition for SED above, includes eligibility at or below 200% of the federal poverty guidelines. Due to the percentage of children in poverty in Indiana (23% plus 21% between 100% and 200% FPL), the prevalence of SED is significantly higher than for the SMI population. The prevalence estimates for Indiana youth with SED are depicted in the following table.

Indiana Children with Serious Emotional Disturbance 2011 Population Estimates

Eligible for DMHA Services (at or below 200% of FPL and 0-17 years)	92,300
GAF <50 (9-17 years only)	73,343
GAF <60 (9-17 years only)	105,940
2011 Indiana Population aged 9-17	814,926
2011 Indiana Population aged 0-17	1,597,603

State Definition of Chronically Addicted (CA)

Indiana Administrative Code (440 IAC 8-2-3) provides the definition of persons who are chronically addicted as follows:

An individual who is chronically addicted is an individual who meets the following requirements:

1. The individual may be any age.
2. The individual has a disorder listed as a substance-related disorder in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association (DSM-IV).
3. The individual experiences significant functional impairments in two (2) of the following areas:
 - Activities of daily living.
 - Interpersonal functioning.
 - Ability to live without recurrent use of chemicals.
 - Psychological functioning.
4. The duration of the addiction has been in excess of twelve (12) months. However, individuals who have experienced amnesiac episodes (blackouts), or have experienced convulsions or other serious medical consequences of withdrawal from a chemical of abuse, or who display significant dangerousness as a result of chemical use, do not have to meet the duration requirement.

Description of Estimation Methodology for Persons Chronically Addicted (CA)

The Division of Mental Health and Addiction (DMHA) utilizes two methodologies to determine estimates of Persons Chronically Addicted (CA) in need of treatment services. First, using the

SAMHSA National Survey of Drug Use and Health (NSDUH) for 2011 estimates of prevalence of persons who are Chronically Addicted and in need of treatment, in Indiana there are an estimated 454,000, or 8.3%, of all 5,462,914 Hoosiers age 12 and above in 2013 with Alcohol and/or Drug Dependence or Abuse in need of treatment. The second method is based on the eligibility requirements for DMHA supported services, which established eligibility at or below 200% of the federal poverty level. An estimated 39.5% of Indiana's population aged 12 and over has incomes at or below 200% of the federal poverty level in 2013. Based on this methodology, the number of persons who are Chronically Addicted and in need who may be eligible for services through the public addiction system in 2013 is estimated at 179,000.

Indiana Adolescents and Adults with Chronic Addiction 2011 Population Estimates

Eligible for DMHA Services (at or below 200% of FPL)	
12-17 years	14,127
18-25 years	55,842
26 years and over	109,136
NSDUH Estimation Methodology	
12-17 years	31,788
18-25 years	143,185
26 years and over	279,836
2011 Indiana Population aged 12-17 (adolescents)	543,595
2011 Indiana Population aged 18-25 (young adults)	740,621
2011 Indiana Population aged 26 or Older (adults)	4,178,698

Criterion 3: Children's Services

Children/Youth Identified As Having Severe Emotional Disturbance (SED)

Demographics

Geography: The 2010 U S Census reports 1,608,298 Indiana youth less than 18 years old, comprising 24.8% of Hoosiers. About 20% (321,000) of Indiana's children and youth are expected to experience mental health needs with 9% to 13% having significant functional impairments and 5% to 9% (80, 000 to 144,750) experiencing severe functional impairments, meeting the federal definition of serious emotional disturbance. During SFY 2010, a total of 42,387 youth in Indiana between the ages of 0-21 years were receiving behavioral health services by DMHA contracted providers.

Age & Gender: Additionally, 53% of all youth who were served by community mental health and addiction providers were between the ages of birth and 12 years of age. The next largest group was those between the ages of 13-17 years (34%). Finally, 13% of youth receiving services were between the ages of 19-21 years. Boys comprised 57% of all youth served.

Race & Ethnicity: The characteristics of Indiana's growing population can be compared with the profile of youth who receive public services. Eighty-four percent of Hoosiers are Caucasian (US Census, 2010) and 9% are African American, 1.6% Asian, 2% report two or more races, and 6% Hispanic. Approximately 71% of all youth in DMHA services are Caucasian, 16% are African American, and about 3% reported being from a multi-racial background. Less than 1% of youth are from Native American, Asian, Native Hawaiian or Pacific Islander heritage. Approximately 6% of youth receiving community-based mental health services identified themselves as being Hispanic or Latino.

Socioeconomics: Of all 42,837 youth in Indiana between the ages of 0-21 years who receive services through DMHA providers, approximately 85% are on Medicaid. A majority, 77%, live below 100% of the poverty level. Another 21% live between 100%-200% of the poverty level. DMHA provides funding to help support the delivery of services to individuals living at or below 200% of poverty or who have Medicaid (including special needs adopted youth). Not included are youth with severe emotional disturbances who live in middle and upper middle income families.

State Hospitals: Indiana has two hospitals that serve youth ages 6-12. One of these hospitals also serves adolescents ages 13-17. Due to the decline in census, part of the state hospital transition plan eliminated adolescent beds at one hospital. DMHA is actively reviewing data surrounding utilization of long-term beds for youth and building capacity within the community through a Psychiatric Residential Treatment Facility Transition Waiver, Money Follows the Person, planned 1915(i) state plan amendment, and continuing System of Care developments.

Current Initiatives (BG Funds)

Statewide System of Care Conference – This annual conference, which celebrated its 10th anniversary this year, is supported by Block Grant, federal and state funds. An Indiana provider started the statewide System of Care conference with federal funds received from SAMSHA (Children's Mental Health Initiative, or CMHI).

Riley Child and Adolescent Psychiatry Clinic - The contract with the Riley Child and Adolescent Psychiatry Program is intended to support a specialty clinic focused on the psychiatric assessment and treatment of youth with substance use disorders and co-morbid mental health issues.

Youth M.O.V.E Indiana - The purpose of this grant is to create and facilitate a Youth MOVE (Motivating Others through Voices of Experience) chapter in Indiana. Youth MOVE will provide the opportunity for Hoosier youth to voice their opinions, advocate, and raise awareness around youth issues and their experience in the mental health and other systems serving young people.

Current Initiatives (Medicaid or Federal Funds)

Psychiatric Residential Treatment Facilities Transition Waiver – This started October 1, 2012, as a means to continue serving the children/youth who were receiving services through the CA-PRTF demonstration grant when it ended on September 30, 2012. The CA-PRTF Grant was authorized under the Deficit Reduction Act and operates under 1915(c) waiver guidelines to provide intensive community-based services to children/youth that would otherwise require psychiatric residential or long-term hospital care. Indiana served over 1,600 children/youth through the CA-PRTF Grant. Two significant outcomes have been realized by this initiative: (1) reduced occupancy on children's units at the two state hospitals serving youth and (2) reduced admissions and overall cost for Psychiatric Residential Treatment Facilities for youth.

Youth Consultant at DMHA – The sustainability plan for the CA-PRTF demonstration grant allowed for Indiana to hire a part-time youth consultant. The youth consultant participates in policy discussions and decisions that affect the youth of Indiana.

Money Follows the Person (MFP) – DMHA worked in collaboration with Division of Aging to complete an application for Money Follows the Person (Rebalancing Act). Indiana currently has MFP for the Aged and Disabled population and added the population “children/youth residing in a psychiatric residential facility or state-operated facility” to the existing program in order to fund their successful transition into the community from institutional care.

System of Care Expansion Planning Grant – DMHA along with the Department of Child Services (DCS) and National Alliance on Mental Illness Indiana received the System of Care Expansion Planning Grant. This grant provides funding to support a State-level System of Care Governance Board in writing a strategic plan. The grant started on July 1, 2013, and ends June 30, 2014.

Trauma and Justice Health Reform Strategic Initiatives - Through the current CMHI cooperative agreement focused on Southeastern Indiana (One Community One Family), efforts are ongoing to transform that area and eventually the entire state to become a trauma-informed System of Care. Training and consultation has been provided by THRIVE, which is the State of Maine's Trauma-informed System of Care. To date, representatives from THRIVE have presented information at the Statewide Indiana Council of Community Mental Health Centers Conference and at the 10th annual Statewide Systems of Care Conference. One Community One Family is

also working with THRIVE to obtain a web-based training for trauma-informed care as well as having local representatives to become trained trainers of trauma-informed care.

Transition Age- Transition to Independence Process (TIP) works with transition-aged youth and young adults (14-29 years old) to assist them in a successful transition into adulthood. One Community One Family has TIP Facilitators and is currently serving transition-aged youth through this process.

Current Initiatives for Youth with Substance Use and Mental Health Challenges

Mental Health Screening for Youth in Juvenile Detention Centers – Since 2006, DMHA has been a standing member of the state-wide advisory board addressing mental health screening and assessment for youth entering juvenile detention facilities. This project is sponsored by the Indiana State Bar Association and includes collaborations with state agencies, juvenile courts, juvenile probation, detention facilities, and universities. A significant finding from data collected through this screening process is that nearly one in three detained youth have significant issues with substance use.

Juvenile Detention Alternatives Initiative (JDAI) – DMHA holds membership on the state-wide Steering Committee for Indiana's JDAI project. JDAI is a comprehensive initiative of eight strategies involving system-wide change in philosophy, practice and policy. There are currently eight (8) counties in Indiana implementing JDAI.

Cooperative Agreement for State Adolescent Treatment Enhancement and Dissemination (SAT-ED) – In 2012, Indiana was awarded the SAT-ED to establish two learning laboratory sites in the state to pilot the implementation of an evidence-based assessment tool and treatment model for adolescents with substance use disorders or co-occurring substance use and mental disorders. This three-year project is designed to expand the use of these evidence-based practices to be provided throughout the state once they have been established at the learning laboratory sites. It is anticipated that the project will help increase the capacity of providers across Indiana to utilize evidence-based practices when working with adolescents with substance use disorders and their families.

Future Initiatives (Medicaid or federal funds)

1915(i) State Plan Amendment – The sustainability plan for the CA-PRTF Grant includes submitting an application for a 1915(i) State Plan Amendment. The state anticipates serving 750 children or youth through this initiative. The population will include children or youth who have been assessed to need intensive community based services in order to remain in their home.

Crisis Intervention Team for Youth (CIT Youth) – This initiative will allow for more police and school resource officers to be trained in CIT for Youth. The training will assist officers when responding to emergency calls that involve a youth with mental challenges.

Criterion 4: Targeted Services (Homeless, Rural Services, and Older Adults)

Homeless

The 2012 Point in Time count showed there were 6,064 homeless individuals counted this past January in Indiana. This is a decrease from 2011 but while there were fewer individuals found homeless there was an increase in homeless families, and those living with others. From that data, 12% were identified as having a serious mental illness and 34% were identified as persons with chronic substance abuse; DMHA believes that these underestimate the prevalence of these disorders in this population. General estimates for the state are that 60,000 persons in any year will experience homelessness. Data from the providers show that there were 4,882 individuals that received services that were homeless.

DMHA receives SAMHSA funding under the Projects for Assistance in the Transition from Homelessness (PATH) grant program which funds twelve mental health centers to provide Homeless Outreach Teams. The PATH teams have focused on the chronically homeless population. The teams are continuing to identify homeless veterans to assure they receive their proper entitlements.

The teams provide the following services:

- Screening and diagnostic treatment services
- Habilitation/rehabilitation services
- Community mental health services
- Staff training
- Case management services
- Supportive and supervisory services
- Residential services
- Referrals for primary health services
- Job training and educational services
- Housing services

All of the PATH teams are a part of comprehensive community mental health centers and the full continuum of services is available to persons who are homeless and enrolled in treatment services. All of the PATH sites have a certified Assertive Community Treatment team operating in the agency.

The target population for the Mobile Homeless Outreach Teams is the homeless individual who is mentally ill and has problems that require professional intervention. Homeless has been defined as including individuals who:

1. May live on the street, in cars, or in abandoned structures or public places;
2. Are housed in emergency shelters and other places not considered home;
3. Are living with friends or relatives in crowded, unhappy, and stressful circumstances;
4. Are living in deteriorated, unsafe housing, often lacking utilities; or
5. Are involved in support programs without which they would be at high risk of homelessness. Some of these individuals may be "chronic" street people while some are on the streets on an episodic basis.

As part of the PATH grant application, DMHA developed a definition of the “at-risk of homeless population”:

A person at imminent risk of becoming homeless includes those who are:

1. living with friends or relatives in a sequence of living arrangements
2. living in a condemned building
3. facing an eviction notice
4. in a county jail with no housing available upon release or
5. in a psychiatric inpatient unit with no housing available upon release

DMHA enjoys a positive working relationship with the Indiana Housing and Community Development Authority and Corporation for Supportive Housing. All CMHCs are actively involved in their local planning councils. DMHA has seen increases in the number of funding applications by CMHCs in the annual SuperNOFA (Notice of Funding Availability) for Housing and Urban Development funding for the homeless. These activities underscore the emphasis that providers have placed on serving the homeless in their areas. There are over 400 units of Shelter Plus Care in the state. This year Indiana was successful in the HUD funding competition, and there are three new projects that are CMHC based that will provide an additional 94 beds for the homeless mentally ill and/or chronic addiction population.

DMHA is on the Interagency Council of the Indiana Housing and Community Development Authority. The council is made up of various agencies that work with the homeless population. A subcommittee of the council, the Homeless Task Force, developed the Indiana plan to end chronic homelessness.

Rural Services

DMHA has defined rural as those counties with fewer than 100 persons per square mile. With the exception of two counties there is at least an outpatient office in every county of the state. Indiana has several metropolitan areas; Indianapolis, Ft. Wayne, South Bend, Evansville, and the northwest section of Lake County; however, most of the state is rural. Historically,

Indiana has maintained a remarkable standing in the provision of mental health and addiction services in rural areas. DMHA tracks the penetration rate of behavioral health services in rural areas. The data indicate that the likelihood of a person receiving services in a rural area is the same as in an urban area.

There is continuing concern about the availability of behavioral health clinicians in many rural areas, especially psychiatrists. Indiana has experienced a decrease in the number of psychiatrists over time and it is increasingly difficult for rural providers to attract psychiatrists. Some providers in rural areas have explored the use of telemedicine to assist those consumers who have difficulty traveling to the nearest provider. DMHA is also on the advisory board of a HRSA grant that will be providing telemedicine for veterans who have difficulty accessing care at the VA hospitals. By using teleconference capabilities the veterans will be able to have psychiatric consultation at one of five rural CMHCs that will be linked to the Indianapolis VA. The CMHCs, in addition to providing space, will provide staff if a crisis situation arises and a personal intervention is needed. This project started with four rural sites and has increased to six sites.

Older Adults

DMHA is aware of the demands on the system that will be created with the aging of the population. For many years, DMHA has required CMHCs to provide services for older adults. Specifically, CMHCs are required to have a plan on how they intend to serve older adults, to designate a contact person for older adult services, and to perform the federally mandated Pre-Admission Screening and Resident Review (PASRR)/Mental Illness (MI) Level II reviews for individuals with serious mental illnesses applying for admission to Medicaid-certified nursing facilities. DMHA continues to provide two training events for PASRR assessors annually. In addition, a state law requires the centers to work with residential facilities to screen applicants for appropriateness of admission and to develop plans of care for individuals with mental illnesses. The CMHCs also provide a variety of other services, including several who have contracts or arrangements with nursing homes and residential facilities to provide mental health services to residents.

In 2010, DMHA partnered with the Indiana Mental Health and Aging Coalition, the National Association of State Mental Health Program Directors (NASMHPD) Older Persons Division, the National Association of PASRR Professionals, and other organizations for an aging conference. The Division is looking at the possibility of hosting a conference in the future to address the mental health and addition needs of Older Adults.

DMHA provided technical assistance to Adult and Child Mental Health Center which is the recipient of a SAMHSA CMHS Older Adult Targeted Capacity Expansion (TCE) Grant. The

purpose of the grant is to implement an enhanced IMPACT program which is recognized as an evidence-based practice.

In December 2012, three divisions of the Indiana Family and Social Services Administration (FSSA) were represented at the SAMHSA Older Americans Regional Policy Academy in Atlanta, Georgia. Representatives attending were from the Division of Mental Health and Addiction (DMHA), the Office of Medicaid Policy and Planning (OMPP), and the Division of Aging.

Based on the state's data, the Indiana team selected two priority issues: 1) suicide prevention among older adults; and 2) lack of identification of mental health and substance use problems among older adults and the need for cross training of providers.

Work on implementing action items on how to address these two priorities was delayed by a change in administration (a new Indiana Governor took office in January 2013) and the resulting change in leadership in the FSSA divisions. (A new FSSA Secretary began work in late February 2013 and OMPP currently has an interim director.) DMHA will meet with partners for the initiative in SFY 2014.

Criterion 5: Management Systems

The Division of Mental Health and Addiction (DMHA) budget for 2014, as passed by the legislature, provides \$276.2 million in state funds for DMHA. Of that amount, \$117 million is budgeted for CMHC's; \$3.2 million is budgeted for DMHA administration; and \$153 million is budgeted for the State Hospitals. There is an additional \$291 million anticipated in Medicaid funding for behavioral health services.

The majority of Mental Health and Substance Abuse Prevention and Treatment Block Grant funds are allocated to the provider agencies. At the end of a fiscal year this office can track the expenditure of Block Grant funds to each provider.

Utilization of the Substance Abuse Prevention and Treatment Block Grant funds include 21% for primary prevention, 74% for treatment, and no more than 5% for administration.

Training

DMHA is involved in a wide range of training events, supporting a variety of areas including but not limited to cultural competence, assessment, recovery, and problem gambling. To begin with, DMHA has a long history of providing training for providers in cultural competence. That training includes minorities and the gay-lesbian populations. Recent discussions will lead to inclusion of military and service member cultures. DMHA is nationally recognized as a leader in disaster mental health services and training for disaster responders. This year the Division of

Mental Health and Addiction completed, with the assistance of many other agencies, the *Indiana State Suicide Prevention Plan*. In addition, a Suicide Prevention Summit will be held in September 2013.

DMHA also sponsors training and certification in the use of the Child and Adolescent Needs and Strengths (CANS) assessment and the Adult Needs and Strengths Assessment (ANSA). Individuals who use the assessment tools must retain certification to use the tools, demonstrating an adequate to high level of inter-rater reliability rating vignettes. Indiana is using a “SuperUser” model, developing local experts who complete more in-depth training regarding how to use information from the assessments and help integrate the tools into every day practice. SuperUsers are supported through annual boosters and ongoing consultation and support. The same training and targeted consultation is provided to behavioral health providers, child welfare staff and providers, participating schools, and auditors.

During National Recovery Month each year, DMHA coordinates the Indiana Annual Recovery Month Symposium (IN ARMS). In September 2013, DMHA will sponsor the sixth IN ARMS. IN ARMS includes presentations related to all behavioral health care. This event was a “sell out” event in 2012 with over 300 persons in attendance, and DMHA anticipates standing room only this year as well. This two-day event will include nationally known presenters as well as a wide range of Indiana-based experts. In addition to excellent sessions on evidence-based programs and practices, IN ARMS affords the opportunity for networking and integrating approaches to mental health and addiction recovery strategies.

DMHA also offers a variety of trainings through the Indiana Prevention Resource Center’s Indiana Problem Gambling Awareness Program (IPGAP). An online training system utilized by the program has allowed multiple trainings to be offered and tracked online. The following is a list of trainings recently offered through IPGAP:

In-Person Trainings:

- Advanced Motivational Interviewing
- Gambling 101
- Problem Gambling 101 Treatment Planning
- Motivational Interviewing
- Problem Gambling 201
- Motivational Interviewing (x2)
- Women & Gambling / Spirituality & Gambling
- Ethics Training
- Co-Occurring / SBIRT / Motivational Interviewing
- Group Practices
- 12-Step Facilitation

- Gambling 101
- Women & Gambling / Women & Trauma / Bereavement & Loss
- Gambling Treatment Basics

Online Trainings:

- Gambling in Indiana: The Basics of Legal Gambling
- If I can't balance my checkbook, how can I help you balance yours?
- Additional trainings and conferences recently offered with the support of DMHA include what is listed below. Indiana Behavioral Health Affordable Care Act Summit
- Systems of Care Conference for Indiana: A statewide, annual event that draws approximately 400 people. DMHA provides \$30,000 every year for this conference.
- Skills for Psychological Recovery: In October 2012, this training was held for DMHA's Crisis Counseling program.
- Resilience in Disaster Mental Health Conference: In February 2012, DMHA held this conference with the support of a Homeland Security Grant.

DRAFT

B. Planning Steps

Planning Step 1

Block Grant Application Instructions:

Step 1: Assess the strengths and needs of the service system to address the specific populations. Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities.

Prevention

Overview of Lead State Agency

Priority Area #1 for Indiana is to promote mental health and to prevent addiction. A major player in prevention across Indiana is the Bureau of Mental Health Promotion and Addiction Prevention. The bureau exists as part of Division of Mental Health and Addiction (DMHA) and provides oversight and administration of the Substance Abuse Prevention and Treatment Block Grant (SABG) to ensure funding that addresses statewide prevention priorities. Its mission, vision, and duties, listed below, play a crucial role in determining goals for the future of Indiana prevention.

Mission: To reduce substance use and abuse and promote behavioral health across the lifespan of Indiana citizens by maintaining a coordinated, effective, and accountable system of prevention and behavioral health promotion services.

Vision: Sustainable environments that nurture, assist, and empower all Indiana citizens to access and experience optimum physical, emotional, and mental health.

Duties:

- Build prevention capacities and infrastructure at the state and community level.
- Prevent onset and reduce the progression of substance use among Indiana residents. Establish consistency in the assessment, design, implementation, and evaluation of prevention services.

- Ensure a standard of professional practice that yields a culturally responsive, dynamic prevention workforce committed to continuous professional development.
- Utilize funding to fulfill unmet needs, support data-driven prevention priorities, and leverage technical assistance from state and national experts and agencies.
- Maintain a broad spectrum of universal, selective, and indicated prevention programs and practices that are data-driven and respond to changing state prevention priorities.
- Maintain contact with federal and state prevention experts to exchange information on best practices for prevention and mental health promotion.
- Manage SABG funds for prevention activities to ensure wise stewardship and effectiveness.
- Provide oversight of the state-endorsed addictions resource center.
- Obtain additional grant funding when available to enhance the prevention system. Ensure the sustainability of the State Epidemiological Outcomes Workgroup and the availability of annual data reports.
- Maintain a statewide system for the collection of data related to prevention and mental health promotion initiatives.
- Provide guidance on policy initiatives related to substance abuse prevention and behavioral health promotion.
- Ensure dissemination of the latest findings from prevention science and best practices.
- Promote the use of a public health model to address needs and priorities.

Guiding Principles

The Indiana prevention system is guided by the latest prevention research and utilizes research to make data-based decisions. In order to carry out prevention efforts effectively and efficiently, Indiana has adopted the Strategic Prevention Framework (SPF). The State of Indiana is committed to expanding the SPF process to coalitions and communities throughout the state. In collaboration with prevention specialists from the Indiana Prevention Resource Center (IPRC), the state of Indiana has created the Community Prevention Framework (CPF) as a guide to Indiana communities as they undertake prevention efforts and move through the SPF process. CPF combines elements of the latest research in prevention science, the SPF, and the Communities That Care (CTC) system. CTC is a five-step prevention planning tool that guides communities in strengthening the prevention infrastructure and decreasing substance abuse as well as its associated consequences. The system incorporates the use of milestones and benchmarks to track progress and focus the efforts of coalitions as well and provides a valuable tool that can be used to guide the provision of technical assistance.

Evidence-Based Practices

The state of Indiana is committed to supporting a broad spectrum of universal, selective, and indicated prevention practices and behavioral health promotion strategies that are data-driven, evidence-based, and responsive to change. This means ensuring funding to fulfill unmet needs and support data-driven priorities.

DMHA will seek to support evidence-based strategies including the following:

- Increasing the perception of risk of substance abuse
- Creating positive norms in a community
- Creating environmental conditions associated with drug and alcohol free lifestyles
- Increasing positive attachment to family, school, neighborhood, and community
- Reducing attitudes favorable toward the problem behavior or use
- Creating substance abuse prevention policy

Setting Priorities

The State Epidemiological Outcomes Workgroup (SEOW) is responsible for determining state priorities for preventing and reducing substance use. After analyzing available data on risk and protective factors, substance use, and consequences, the SEOW determined four priorities and set objectives to reduce use in these areas by 2017. The main factors considered in determining the priority areas were which substances affected the largest number of Hoosiers (including substances with the highest rates of use) as well as whether trends indicated an increase in use of a certain substance. State readiness to address the priorities was also considered.

The four substance abuse prevention priority areas for 2012 to 2017 were determined to be alcohol, tobacco, prescription drugs, and marijuana. These priorities, along with each substance's baseline and target rates of use, are on the following pages. Baseline information, referring to the current percentage of reported use, was determined by reviewing the Indiana rates from the most recent year of data available for national surveys such as the National Survey on Drug Use and Health (NSDUH) and the Behavioral Health Risk Factor Surveillance System (BRFSS). Target rates of use, the goal percentages of reported use to be reached by 2017, were determined by reviewing the criteria set forth in Healthy People 2020, a product of the U.S. Department of Health and Human Services that provides structure and guidance for improving the nation's health, including 10-year goals and action steps to achieve various health outcomes.

Priority Populations

Indiana is committed to expanding the scope of statewide prevention activities to include a focus on the lifespan as well as promoting an understanding of the sphere of influence. The sphere of influence suggests interventions aimed at a target group may need to occur in other domains or age groups that exert influence on the target group. As such the state also embraces the use of environmental strategies to create population level change.

In November 2011, Indiana received a SEOW program contract to support the integration of substance abuse prevention and mental health promotion efforts and to expand the focus of the SEOW's work. As part of the grant, the state sought to identify new high-risk populations, specifically those believed to be at high risk but about which not much is known. These discussions resulted in the identification of four new high-risk populations:

- Individuals with past or current military involvement and their families
- Individuals previously incarcerated
- Individuals identifying as LGBTQ
- Individuals with co-occurring disorders

Collaborations

DMHA convenes a prevention committee made up of stakeholders from various sectors including: military, education, research/data collection, criminal justice, advocacy/policy, and children's services. DMHA also works with various other state agencies, non-profit organizations, and schools to implement evidence-based programs that target risk factors that produce poor mental health and substance abuse outcomes. DMHA supports the provision of statewide trainings through a contract with the Indiana Prevention Resource Center and Mental Health America Indiana. The Indiana Criminal Justice Institute (ICJI) is a strong partner in state prevention activities. ICJI seeks to reduce the incidence and prevalence of substance abuse through the work of the Governor's Commission for a Drug Free Indiana and the 92 Local Coordinating Councils around the state. Through the 92 Local Coordinating Councils, the Commission interacts with over 3,400 Hoosier citizens. These individuals represent multiple sectors in their communities, including, but not limited to: state and local law enforcement, school personnel, mental health and substance abuse counselors, prosecutors' offices, members of the faith-based community, elected officials and other concerned citizens. The result is a very robust and diverse collection of individuals committed to finding local solutions. DMHA will continue cultivating relationships with other state agencies to enhance the state prevention system.

Intravenous Drug Use (IVDU)

According to the Statewide Epidemiological Outcomes Workgroup (SEOW) reports, Indiana does not have specific data on IVDU. A March 2010 Indiana University – Purdue University at Indianapolis (IUPUI) Center for Health Policy report estimated 10,800 persons injecting drugs. Updating for 2011, the United States Census for Indiana of persons age 12 and above was 5,365,682. Substance Abuse Mental Health Services Administration (SAMHSA) currently estimates that 8.27% of these individuals are in need of treatment for addiction at any one moment in time during the year. Using the SAMHSA estimate approximately 444,000 Hoosiers

age 12 and older are in need of addiction treatment today. SAMHSA also estimates that 0.17% of Americans age 12 and older have used drugs intravenously in the past year. Using the SAMHSA estimate, approximately 9,121 Hoosiers have used drugs intravenously in the past year. In State Fiscal Year 2012, 4,048 persons with IVDU were treated for chronic addiction, a 44.38% penetration rate in the total estimates of current persons with IVDU.

Since IVDU is rarely an early experimental step in drug use, and is often a sign of progression of addiction to cocaine, opiates, methamphetamine, and other sedative drugs, including illicit use of prescription drugs, this would indicate that 1.89% of Hoosiers are in need of treatment for addiction with IVDU. This relatively low percentage is a result of the fact that most people use alcohol, tobacco and/or marijuana which are almost never used intravenously. And, the drugs used intravenously are not frequently used, such as current use of cocaine at 0.7%, methamphetamine at 0.2% and heroin at less than 0.01%, according to the SEOW report, *Consumption and Consequences of Alcohol, Tobacco, and Drugs in Indiana: A State Epidemiological Profile 2012*.

Intravenous Drug Use (IVDU) Strengths

Certainly a major strength in Indiana's strategies in addressing intravenous drug use is the cooperative and collaborative approach of providers, Indiana State Department of Health, and Indiana Division of Mental Health and Addiction, as evidenced by the estimate that over one out of three persons with current IVDU were treated for chronic addiction during the past year.

Intravenous Drug Use (IVDU) Needs

While the assessment above offers reasonable estimates and factors, these are only estimates in the absence of specific data and methodologies. Things needed to improve services in Indiana to persons with IVDU include a need for actual baseline and ongoing Indiana specific data on IVDU, more varied Evidenced-Based Practices (EBPs) on outreach, intervention and treatment of persons with IVDU particularly in rural and other regionally specific groups, outreach methods, including EBPs for outreach in rural areas and specific groups such as youth, GLBTQ individuals, and relative outcome data for persons with and without IVDU.

Children at Risk, Adolescents with Substance Use and Mental Health Challenges, and Transitional-Aged Youth

DMHA considers the child and adolescent services and programs that have developed across the State to be a primary strength of the system. Systems of Care offering wraparound services are available in most communities. Indiana has been the recipient of three SAMHSA Child Mental Health Initiative grants. Indiana has worked with the Centers for Medicare and Medicaid (CMS) to develop Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF)

with five years of Medicaid funding. DMHA is also involved with other State agencies and public entities to improve the social, emotional, and behavioral health of youth in Indiana. (See details in the section for Criteria 3.)

Two significant outcomes have been realized through these efforts:

- Reduced occupancy on children's units at the two state hospitals
- Reduced admissions and overall cost for Psychiatric Residential Treatment Facilities

Currently, there remain several concerns about the youth in Indiana. Some of these concerns are:

- High rates of suicide
- Lack of statewide trauma informed care programs
- Poor outcomes for youth involved with serious substance use
- Inadequate services for, and engagement of, youth transitioning from adolescents to adulthood

Each of these areas has been addressed through high level planning activities. The Indiana State Suicide Prevention Plan includes teenagers and young adults as a specific population, and DMHA and other organizations have partnered to increase training and awareness of trauma-informed care practices. Although actual implementation of programs and services to directly address these areas will be long-term, DMHA is committed to continuing the dialogues and planning activities that will lead to successful outcomes.

Pregnant Women and Women with Dependent Children

DMHA is involved in the Prenatal Substance Abuse Cross-Agency Committee (PSACAC) with the Office of Medicaid Policy and Planning, Indiana Tobacco Prevention and Cessation, the Indiana State Department of Health, The Indiana Perinatal Network, and First Steps. PSACAC is working on the development of a framework for addressing prenatal substance abuse across systems.

The Prenatal Substance Use Prevention Program (PSUPP) is a prevention program administered by the Indiana State Department of Health and funded by the Indiana Division of Mental Health and Addiction, the Indiana Tobacco Prevention and Cessation Program, and the Maternal and Child Health Services. It supports community grants across the state for the program Baby and Me: Tobacco-Free or other evidence-based perinatal addiction prevention strategies. The goal of this program is to prevent poor birth outcomes, by attempting to encourage women who are pregnant to decrease or eliminate alcohol, tobacco and other drug use.

SABG funds are used to support six residential programs for women who are pregnant and/or

have dependent children. The SABG requires a Maintenance of Effort (MOE), minimum obligation of funding, of \$2,775,760 for treatment of pregnant women and women with dependent children. In SFY 2012 Indiana spent an estimated \$4,056,362, more than the required MOE. In SFY 2012, 3,248 women during pregnancy and/or women with dependent children, including 291 pregnant women received services. This results in an average allocation of \$1,248.88 per consumer.

Indiana's Access to Recovery (ATR) grant serves the target population of women who are pregnant or have dependent children in eleven counties. This has allowed DMHA to work at the State and community level with agencies like the Department of Child Services and the State Department of Health who provide programs and services that either serve or include parents who have a substance use problems or disorders.

Gaps/Needs

There is a need for additional training and technical support for evidence based gender specific treatment and interventions to be delivered to women who are pregnant and women with dependent children. Providers to be trained on core competencies as outlined by SAMHSA- "Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals."

Parents with Substance Use and/or Mental Health Disorders that Have Dependent Children

Indiana Access to Recovery (INATR) is a four year federal grant which was awarded to DMHA in October 2010 by SAMSHA. INATR assists clients who want to get in recovery from substance use problems and disorders or need assistance maintaining their recovery. INATR pilots a recovery-oriented approach to care and helps clients gain access to a network of clinical, community and faith-based organizations who provide treatment and recovery support services to eligible individuals. INATR currently offers parenting support including respite care and family and/or marital counseling which have a parenting component.

Parenting support provides services that help alleviate roadblocks to the client's recovery caused by a lack of child care which hinders their ability to engage in substance abuse treatment and recovery support services. Such services might include respite care, baby-sitting, and limited day-care. Family and marital counseling provides personal, spousal, and full-family counseling tailored specifically to the issues identified in an in-depth assessment that relate to the client's recovery and the effects their use has had on their family members. Services provided should engage the entire family system to address issues such as interpersonal communication, co-dependency, conflict, marital issues and concerns, parenting issues, family reunification, and strategies to reduce or minimize the negative effects of substance abuse on the relationships.

HIV/AIDS, TB, and Other Diseases Current Services

The Division of Mental Health and Addiction (DMHA) has a Memorandum of Understanding (MOU) with the Indiana State Department of Health (ISDH) for IVDU outreach as part of an ISDH overall program of community outreach and communicable disease prevention and intervention. ISDH has a baseline and ongoing Indiana data specific to intravenous drug use (IVDU). IVDU data is collected through the Division's Office of Clinical Data and Research (OCDR) as case reports of new infections submitted from various service providers. The Special Populations Support Program (SPSP) also collects various demographic and substance use data, including IVDU risk, during outreach, risk assessment, and testing activities. Additionally, some IVDU data is collected through general prevention and testing activities that are provided through the Division. However, this funding is on hold due to sequestration funding decreases.

All SPSP vendors have been trained extensively in the areas of Harm Reduction and Motivational Interviewing. Harm Reduction strategies are taught during the course of outreach, testing, and supportive care activities. Motivational Interviewing is utilized to improve adherence to care plans and to encourage behavior change that might be beneficial to the client. Additionally, referrals are made to various treatment providers that may use other evidence based practices that are individualized to the client. Both Harm Reduction and Motivational Interviewing are accepted EBPs for behavior change. For Harm Reduction, please refer to *State of the Art in Harm Reduction Psychotherapy: An Emerging Treatment for Substance Misuse Journal of Clinical Psychology: In Session*, Vol. 66 (2), 117-122 (2010). For Motivational Interviewing, refer to The Center for EBP at *Case Western Reserve University-Mandel School of Applied Sciences and Department of Psychiatry, School of Medicine*.

SPSP outreach activities are conducted in various venues including geographically diverse DMHA-licensed drug treatment facilities, jails, drug courts, probation offices, homeless shelters, and other locations where the target population can be found. Due to the very nature of substance abuse, a highly diverse mix of individuals is encountered including but not limited to people who are youths, gay, lesbian, bi-sexual, and transgendered. Because the SPSP grantees are typically agencies that have worked in the HIV service arena for years, they are trusted and well-known in their respective communities for serving this population.

HIV/AIDS, TB and Other Diseases Strengths

Certainly a major strength in Indiana's strategies in addressing HIV/AIDS, TB and other diseases is the cooperative and collaborative approach of Indiana State Department of Health, Indiana Division of Mental Health and Addiction, and providers, as evidenced by the estimated of numbers of persons with substance use disorders and IVDU participating in treatment.

HIV/AIDS, TB and Other Diseases Needs

While the assessment above offers reasonable estimates and factors, these are only estimates in the absence of specific data and methodologies. Things needed to improve services in Indiana to persons with HIV/AIDS, TB and other diseases include a need for actual baseline and ongoing Indiana specific data on incidence in the general population, more varied Evidenced-Based Practices (EBPs) for outreach, intervention and treatment of persons with substance use disorders, including IVDU, particularly in rural and other regionally specific groups, outreach methods, including EBPs for outreach in rural areas and specific groups such as youth, LGBTQ and aging individuals, and relative outcome data for persons with and without HIV/AIDS, TB and other diseases.

Recovery Supports

Recovery Supports is DMHA's Priority Area #2. One of DMHA's primary objectives for all persons is full access to all services and supports that will assist them in their recovery journeys. Treatment services at the right time and in the right amount will be essential to support the person's recovery. However, treatment alone is not sufficient. Persons with mental illness and/or addiction can be supported in their recovery by additional supports including the following:

- Safe, affordable, and accessible housing that is fully integrated within the community
- Opportunities for gainful employment
- Social networks
- Educational, recreational, and spiritual access

Consumer-operated businesses can provide an opportunity for recovery support and community inclusion. DMHA, using funds from the Block Grant, has funded eight consumer-operated Businesses with the intent of assisting consumers in expanding their support networks by providing friendly environments, peer-run centers, and training in WRAP and Whole Health Action Management (WHAM). KEY Consumer Organization has received Mental Health Block Grant funds for several years to work with consumers interested in establishing local consumer advocacy organizations. KEY provides many exemplary supports, such as Wellness Recovery Action Plan trainings; Warm-Line, a peer-support phone line; additional peer support services; and support groups. Family Action Network has received Mental Health Block Grant funds to develop self-sustaining family support groups in communities that have established a System of Care. The National Alliance on Mental Illness has received Mental Health Block Grant funds to provide peer-to-peer and family-to-family training.

Non-traditional services and supports have been used by the Access to Recovery (ATR) grants from SAMHSA and the Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) demonstration grant from the Centers for Medicare and Medicaid Services.

Data is beginning to demonstrate that these non-traditional services and supports may be having a positive impact on a person's recovery outcomes. In 2012 and 2013, a variety of surveys were conducted among behavioral health providers, consumers, and their families. Initial results indicate satisfaction of recovery services. In addition, a Recovery Supports Statewide Gap Analysis report was completed in November 2012 that identified supports that have funding, those that have no funding, and other supports that are provided without funding support. This report included recommendations for including all recovery supports. Moving forward, state planning activities for 2014-2015 regarding the recovery supports priority area include increasing provider and community knowledge, acquisition, and implementation of recovery supports. DMHA will continue to explore which recovery supports need additional funding support in the state.

Since these are non-traditional services, they are currently available to a small number of persons in Indiana. If these services are found to be effective based on the planning cycle data collection and analysis, DMHA will then identify administrative actions that can lead to broader adoption.

A sampling of ATR non-traditional services includes the following:

- Community-based Continuing Care
- Emergency Housing
- G.E.D. Test
- Group Community and/or Faith Based Support
- Group G.E.D. and Supportive Education
- Group Parenting Education
- Individual Community and/or Faith Based Support
- Individual G.E.D. and Supportive Education
- Individual Parenting Education
- Parenting Support Services - Respite Child Care
- Peer Coaching
- Transitional Housing Assistance
- Transportation Agency Vehicle
- Transportation Bus/Van/Cab - ticketed/billed

A sampling of CA-PRTF non-traditional services includes the following:

- Wraparound Facilitation

- Consultative Clinical and Therapeutic
- Training and Support for Unpaid Caregivers
- Habilitation
- Respite
- Non-Medical Transportation

Grants were also awarded in SFY 2014 to community mental health centers (CMHCs) to improve community-based recovery supports in order to divert consumers from requiring state hospital stays and to improve their access to community-based environments.

Safe and Affordable Homes in the Community for All Consumers (Housing)

DMHA's Priority Area #3 is safe and affordable homes in the community for all consumers. The basis for this priority area was confirmed with the consumer-family survey conducted as part of the Recovery Supports priority area. When asked what contributes to their recovery journey, one of the over-arching needs given by consumers is safe, affordable, and accessible housing that is integrated within the community. DMHA believes that this is an area of the consumer's life that requires consistent coordination between the consumer, the consumer's family and friends (when possible), the behavioral health care provider, and the individuals and organizations within the community that provide housing. To the greatest extent possible, consumer choice must drive where to live and with whom to live.

Historically, community mental health centers have provided a range of residential services. These tended to be group homes and other congregate living facilities. While the providers fulfilled the residential requirements, safe and affordable independent housing is not readily available for all consumers served in the public behavioral health system. Many housing initiatives with varying amounts of available housing stock across the state exist, and availability depends on the area of the state in which the consumer lives. This leads to difficulty in locating housing that appeals to the consumer and connecting with on-provider landlords who are accepting of persons with behavioral health challenges. DMHA is currently exploring options for increasing the utilization of supportive housing.

Indiana has made positive strides toward developing partnerships within a community that are intended to lead to housing options for the consumers. The Indiana Housing and Community Development Authority (IHCDA), in conjunction with the Corporation for Supportive Housing (CSH), has provided a series of Supportive Housing Institutes, which is designed to help providers establish new and innovative relationships with local funders of housing and local providers of housing, with the intention of establishing a new dynamic in housing in which the treatment provider focuses on treatment and the housing provider focuses on housing. This has

highlighted the benefits of multi-agency efforts to blend funding and to make available necessary recovery supports. Efforts were also made to further define a supportive housing model. Specifically, supportive housing services were cross-walked to Medicaid-covered services. This led to the identification of those supports that may require DMHA funding.

In addition to these initiatives, Indiana has a Center for Medicare and Medicaid Services Real Choice Systems Change Grant award related to housing and homelessness through IHCD and the State Medicaid Agency. IHCD has also submitted a grant application for increased Section 811 supportive housing funding that is closely linked to DMHA and its contracted providers.

Integration of Primary and Behavioral Health Care

Integration of Primary and Behavioral Health Care (IPBHC) is Priority Area #4 for the state. This priority was established as a result of stakeholder feedback and the growing awareness that individuals with behavioral health issues die 20-25 years younger than the general population. Utilizing a whole health approach to care is critical in improving overall health and well-being.

The Indiana State Department of Health (ISDH), Office of Medicaid Policy and Planning (OMPP), and DMHA are the primary state agencies leading and supporting the integration initiative. Five Primary Care Behavioral Health Integration (PCBHI) sub-committees were formed (January 2012) based on surveying stakeholders to identify the greatest needs and barriers. The subcommittees are as follows: Education and Training, Policy Development, Funding and Billing, Technology and Data, and Health Homes. The joint goal of ISDH, OMPP, and DMHA is to develop standards and policies to promote best practice implementation and delivery of integrated care across Indiana.

The Division of Mental Health and Addiction (DMHA) in collaboration with its integration stakeholder cross-agency partners submitted a Technical Transfer Initiative (TTI) grant proposal and was awarded funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Association of State Mental Health Program Directors (NASMHPD). Indiana is receiving the 2013 TTI award to further the system transformation to include a whole health approach to recovery with the focus on integration of behavioral and primary health care. In order to accomplish this, Indiana has proposed to use TTI funding to develop a strategic plan incorporating recommendations from each of the subcommittees which will address the following:

- 1) Develop certification/endorsement standards to formalize integration implementation.
- 2) Develop strategies for linking funding to support best practice implementation.

- 3) Develop strategies for building capacity for real time communication through technology.
- 4) Explore and develop recommendations for implementation of Health Homes which embrace best practice integration standards.
- 5) Training and education-
 - a) Develop and implement cross-training between certified recovery specialists (DMHA peer specialists) and community health workers (ISDH)
 - b) Facilitate a training and technical assistance series to prepare for and enhance delivery of best practices to address cross-system training on cultural competency, brief solution-focused behavioral health interventions for a primary care setting, the promotion of use of peers in a whole health approach (Certified Recovery Specialists and Community Health Workers); educating providers on best practice principles to improve outcomes; and assessing and treating individuals from a whole health perspective.
- 6) Hire a project leader to coordinate and facilitate the development of a strategic plan for formalizing integrated care across Indiana; research best practices; coordinate cross-agency initiatives/sub-committees; and coordinate formalized designation endorsed by ISDH, OMPP, and DMHA which would lead to enhanced reimbursement for recognized /endorsed/certified integrated care entities. Post-grant period implementation activities such as rule promulgation, legislative action and operationalizing and carrying forward the integration structure and framework designed under the TTI activities will be assumed by the three lead integration state agencies (OMPP, ISDH, and DMHA).

Indiana's IPBHC collaborative priority initiative, along with the TTI project, is intended to strengthen Indiana's readiness for health care reform implementation and improve quality of life and overall health of individuals with behavioral health challenges. Strategies proposed included workforce development; training, technical assistance, and supervision for staff in an integrated practice; behavioral health/primary care cultural competency; brief interventions; assessment; and outcomes. Indiana proposes building on existing partnerships with ISDH and Affiliated Service Providers of Indiana to educate and promote the use/employment of cross-trained Community Health Workers and Certified Recovery Specialists; and formalizing the definition of integration, establishing best practice standards for consistency in implementation, and promoting activities to improved outcomes for individuals in need of behavioral health and primary care.

Racial and Ethnic Minorities and LGBTQ

The Indiana Division of Mental Health and Addiction (DMHA) continues to focus on providing services to the underserved racial and ethnic minority populations. The targeted populations include (but are not limited to) African-Americans, Hispanics/Latinos, Asian-Americans, Native-Americans, Hawaiians or Pacific Islanders. National data states that the racial, ethnic minority and LGBTQ groups are at a higher risk for substance use disorder and mental illness. National data also suggests that these groups are underserved in receiving services in the mental health and addiction arena. Historically, minority groups are less likely to seek treatment than white Americans.

Indiana continues to have limited collection of data on the LGBTQ population. Some progress has been made since the 2012-2013 state plan was developed, including the addition of questions regarding sexual orientation to the Indiana College Substance Use Survey in 2012, to Indiana's Behavioral Health Risk Factor Surveillance System survey in 2011, and to Indiana's Youth Risk Behavior Surveillance System in 2013. Nonetheless, LGBTQ adolescents and young adults remain largely unidentified rendering any surveillance on substance use and mental illness within the population difficult. This lack of LGBTQ substance abuse data has been identified by State agency reports (Indiana Tobacco Use Disparities and Diversity (ITDD) Workgroup, 2003) and community organizations serving LGBTQ Youth. In addition, the State Epidemiological Outcomes Workgroup (SEOW) has identified individuals identifying as LGBTQ as a priority population. The SEOW conducted a survey in 2012 regarding health issues affecting the LGBTQ community, and will be publishing a supplement to its annual State Epidemiological Profile in September 2013 containing the survey results and other available data. This is a gap that will continue to be examined as DMHA works with other State agencies and community organizations to increase the availability of data as well as services able to address the needs of these individuals.

DMHA has contracted for Cultural Competency training services and technical assistance since 1996. This training is made available to mental health and addiction providers throughout Indiana. The training addresses racial/ethnic/sexual orientation cultural issues. The 17 year life for this program and the regular changes to the curriculum are considered strengths of the system.

The most notable need related the racial, ethnic, LGBTQ populations is the collection of data on sexual orientation/identity and primary language spoken. DMHA data does verify that a disproportionate percentage of persons being served are from racial or ethnic minority groups. Indiana has a growing population of persons whose first language is Spanish continues to pose a major barrier to receiving mental health and/or addiction treatment.

Critical Populations

The Division of Mental Health and Addiction (DMHA) Critical Populations Bureau is designed to address the special issues of those with either mental illness or a substance abuse that also have a physical disability. Critical populations are defined as individuals or groups that have traditionally not been served or have been underserved in the Mental Health and Addiction arena. These individuals or groups are linked together by common factors such as poverty, disability, lack of or poor insurance, lack of accessibility to the mental health and addiction care system, mobility, and so on. Populations that are disproportionately affected in the mental health and addiction system that DMHA targets to provide services include, but are not limited to, African-Americans, Hispanic/Latino, Asian-Americans, Native-Americans, Hawaiian or Pacific Islanders, persons who are homeless, older adults, persons who are deaf or hearing-impaired, persons with disabilities, migrants, and person with HIV/AIDS. DMHA continues to expand its ongoing network of relationships among consumers, family members, providers, community organizations, advocates, agencies, and concerned citizens locally and nationally in order to enhance participation in our programs, goals and objectives.

DMHA has provided staffing support for the Deaf and Hard of Hearing population in Indiana. The Critical Populations Bureau works with providers to identify mental health and addiction needs for persons who are deaf or hard of hearing. DMHA works closely with the state Deaf Services Office in the Division of Rehabilitation and Disabilities (DDRS) to address the needs of this population.

Persons with disabilities have been identified by DMHA as a special population. Lack of resources to address additional services for this population is viewed as a specific need with providers.

B. Planning Steps

Step 2

Block Grant Application Instructions:

Step 2: Identify the unmet service needs and critical gaps within the current system. *This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.*

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, and the Uniform Reporting System (URS). Those states that have an SEOW should describe its composition and contribution to the process for primary 48

prevention and treatment planning. States should also continue to use the historically reported prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish substance abuse prevention, mental health treatment, and substance abuse treatment goals at the state-level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

Data Used in Determining Needs

A variety of data sources are used on an ongoing basis to determine the needs and gaps in Indiana's mental health and addiction system. To begin with, the State has a detailed database for community mental health and substance abuse services. To the greatest extent possible, the same data elements apply to both populations of individuals in treatment. Through the first two years of the combined block grant, the State has used a committee/workgroup structure for each of the four main priorities established for 2012 – 2013. Each group has established processes for completing the needs assessment specific to the priority area. Notably, the community mental health and addiction database did not contain sufficient information to fully assess needs in any of the priority areas. Therefore, each group identified other data sources or created a data collection process for the needs assessment. A summary of each priority area's needs, as well as what processes were used to determine those needs, is given below.

Priority Area #1: Promote Mental Health and Prevent Addiction

The workgroups for addiction prevention and mental health promotion utilized data to develop the strategic plans for suicide prevention and for substance abuse prevention, both of which were completed in 2013. The Bureau of Mental Health Promotion and Addiction Prevention identifies the following enhancement priority areas based on current needs in the Indiana prevention system: 1) enhance data and evaluation, 2) enhance the prevention workforce, and 3) enhance the delivery of prevention services. Regarding substance abuse prevention, the state has also identified the four priority substances of the prevention/reduction of alcohol, marijuana, prescription drug, and tobacco use and their associated goals through the State Epidemiological Outcomes Workgroup. In addition, the Suicide Prevention Advisory Committee identified needs and goals in the areas of suicide awareness, prevention, intervention, postvention, and evaluation. Populations that are considered to be in high need or traditionally under-served have also been identified.

Priorities and needs in prevention have been identified through various data sources. Indiana is committed to the use of data to guide decision-making and select priorities through ongoing assessment. Assessment, the first step of the Strategic Prevention Framework, is crucial to identifying the needs, priorities, and resources related to prevention in a community. The collection of assessment data also plays a large role in being able to determine whether strategies implemented have been successful. Thus, Indiana works to ensure that assessment data is regularly collected and reviewed. The State Epidemiology and Outcomes Workgroup (SEOW) works to collate and analyze available epidemiological data and reports findings to the state's advisory body, MHAPAC, to facilitate data-based decision making regarding substance abuse prevention initiatives across the state.

The SEOW consists of members appointed by various state government agencies, all with the common goal to prevent and reduce substance abuse and its consequences in Indiana. Current membership includes representatives from the following entities: Division of Mental Health and Addiction, Indiana State Department of Health, Indiana Department of Education, Indiana State Board of Pharmacy, Indiana Criminal Justice Institute, Indiana Department of Correction, Indiana State Police, and the Indiana State Department of Health - Tobacco Prevention and Cessation section. Staff at the Indiana University – Purdue University (IUPUI) Center for Health Policy coordinate the work of the SEOW and provide administrative and data analytic services. The goals of Indiana's SEOW are: (1) Update state and local findings on substance abuse and mental health; (2) Address gaps in state and local data on substance abuse and mental health; and (3) Expand state and local data on risk and protective factors related to substance abuse and mental health. All of these goals are guided by SAMHSA's integrative model of behavioral health, i.e., incorporating the prevention of substance abuse and mental illness and promotion of positive mental health.

The SEOW produces an annual state epidemiological profile based on the most recent data available. The profile is made available to the public each year and presents detailed information through graphs, tables, and descriptive analyses regarding the patterns and consequences of substance use both for the state and, whenever possible, each of Indiana's 92 counties. Sources used to compile the report include: Alcohol-Related Disease Impact (ARDI) Database; Alcohol, Tobacco, and Other Drug Use by Indiana Children and Adolescents (ATOD) Survey; Automated Reporting Information Exchange System (ARIES) and Fatality Analysis Reporting System (FARS); Behavioral Risk Factor Surveillance System (BRFSS) Survey; Data Assessment Registry Mental Health and Addiction (DARMHA) system; Hospital Discharge Data; Indiana Adult Tobacco Survey (IN ATS); Indiana Meth Lab Statistics and National Clandestine Laboratory Seizure System (NCLSS); Indiana Mortality Data and National Vital Statistics System (NVSS); Indiana Scheduled Prescription Electronic Collection & Tracking (INSPECT); Indiana Youth Tobacco Survey (IYTS) and National Youth Tobacco Survey (NYTS); Monitoring the Future (MTF) Survey; National Survey on Drug Use and Health (NSDUH); DMHA Prevalence of Illness Reports; Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC); Treatment Episode Data Set (TEDS); Uniform Crime Reporting Program (UCR); Youth Risk Behavior Surveillance System (YRBSS).

Two annual surveys included in the state profile are the Alcohol, Tobacco, and Other Drug Use (ATOD) Survey and the Indiana College Substance Use Survey. The ATOD survey, taken by 6-12th graders, and the college survey help to measure patterns of substance use, mental health indicators, and risk and protective factors of participants. The ATOD Survey identifies patterns within groups and includes measures for ethnicity, gender, and parental characteristics such as incarceration or military status. Communities in the Community Prevention Framework, introduced in the next section, should advocate for these surveys to be taken in their school systems and any colleges in their community. In addition, communities are expected to obtain local-level data to help them assess their needs. The state has recently adopted a web-based data collection system for prevention that will make reporting basic data sets easier.

Regarding suicide prevention, the Indiana State Suicide Prevention Plan identifies several needs and priorities in Indiana that were determined by utilizing data sources including those used by the SEOW and additional data sources. The plan addresses specific populations to be recognized in regard to suicide prevention, including teenagers and young adults, the LGBTQ population, older adults, ethnic and racial minority groups, and the military. The Suicide Prevention Advisory Committee is working to further disseminate the plan so that it may be implemented.

The goals, strategies, and performance indicators for Priority Area #1: Promote Mental Health and Prevent Addiction are available in Table 1.

Priority Area #2: Recovery Supports

Needs related to the area of recovery supports include the continued need for data on non-traditional recovery supports as well as the need to increase the support, knowledge, and availability of recovery supports across the state. Recovery supports data was available for three small grant programs managed by the Division of Mental Health and Addiction. Each of these programs provided non-traditional supports for the individuals being served with the grant funds.

These data were used to identify the supports most utilized and valued by those individuals. In order to obtain a broader database of non-traditional (or non-treatment) supports valued and needed by individuals who access mental health and addiction treatment services and their families, two additional data collection efforts were completed. Persons living in the community in residential settings and in state hospitals were interviewed by state staff to identify what types of support were needed for their recovery. Providers, family members, and consumers were surveyed separately about supports that were available, were used, and were found to be of value for recovery. All data was analyzed by the workgroup, documented in two papers, and formed the basis for 2014 – 2015 planning.

The goals, strategies, and performance indicators for Priority Area #2: Recovery Supports are available in Table 1.

Priority Area #3: Safe and Affordable Homes in the Community for All Consumers (Housing)

Current gaps related to the priority area of housing include a need to clarify and increase data on housing issues as well as the need to develop a strategic plan that addresses housing. There is an additional need to add a rule regarding the provision of or assistance in securing independent housing.

The data show that for the combined substance abuse and mental health populations, there are 4% that are homeless; 3% that are in a residential setting; and 4% that are in supported living. While 82% are reported as living independently, many of those are living with a family member and may or may not have independent housing as the family members age. Work will need to be done in order to clarify the data on independent housing.

The goals, strategies, and performance indicators for Priority Area #3: Safe and Affordable Homes in the Community for All Consumers are available in Table 1.

Priority Area #4: Integration of Primary and Behavioral Health Care

Planning for integration of primary and behavioral health presented a significant challenge in identifying data strategies that could form the basis for an array of state endorsed integration models. The four HRSA-funded sites in Indiana were part of the planning process and contributed information about data collection across different practice models. A subgroup of representatives from the SMHA/SSA, Indiana State Department of Health, and Office of Medicaid Policy and Planning formed a large stakeholder advisory group and five subcommittees. The Data and Technology Subcommittee members were tasked with identifying data issues related to integration. The data subgroup for this priority area has been looking at the Affordable Care Act requirements for the future, electronic health records, meaningful use issues, and the health insurance marketplace. A significant outcome has been that two CMHCs have started working with a health information exchange for sharing of primary health data and behavioral health data. The workgroup for integration will continue to collect information and explore outcomes being obtained through the various integration models in use. The need still exists to identify best practices for integration.

The goals, strategies, and performance indicators for Priority Area #4: Integration of Primary and Behavioral Health Care are available in Table 1.

Other Gaps and Needs

In addition to the needs identified in Indiana's four priority areas, other gaps and needs were identified in the 2014-2015 planning process. A summary of these gaps and needs is below.

Intravenous Drug Use (IVDU)

- Baseline and ongoing Indiana specific data on IVDU
- More evidence-based practices (EBPs) on outreach, intervention and treatment of persons with IVDU particularly in rural and other regionally specific group
- Outreach methods, including EBPs for outreach in rural areas and specific groups such as youth, GLBTQ individuals
- Relative outcome data for persons with and without IVDU

Women's Programming

- Additional training and technical support for evidence-based, gender-specific treatment and interventions to be delivered to pregnant women and women with dependent children

HIV-AIDS, TB, and Other Diseases

- Actual baseline and ongoing Indiana specific data on incidence in the general population
- More evidence-based practices (EBPs) for outreach, intervention and treatment of persons with substance use disorders, including IVDU, particularly in rural and other regionally specific groups
- Outreach methods, including EBPs for outreach in rural areas and specific groups such as youth, LGBTQ and aging individuals, and relative outcome data for persons with and without HIV/AIDS, TB, and other diseases

Older Adults

- Increased suicide prevention efforts for older adults, as identified through the participation in the SAMHSA Older Americans Regional Policy Academy
- Increased identification of mental health and substance use problems among older adults and the need for cross-training of providers, as identified through the policy academy

Underserved Racial and Ethnic Minorities, LGBTQ, and Other Critical Populations

- The collection of data on sexual orientation/identity and primary language spoken
- Persons whose first language is Spanish face a major barrier to receiving mental health and/or addiction treatment.
- Lack of resources to address additional services for persons with disabilities

C. Coverage for Mental and/or Substance Use Disorder Services

Block Grant Application Instructions: Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?

At the time of this writing, the Indiana Division of Mental Health and Addiction (DMHA) is unsure of the Medicaid coverage or the status of any QHPs in the state. Therefore, it is unknown what services will be covered by Medicaid or by QHPs. DMHA is partnering in meetings with Medicaid to assess and ensure parity is in place moving forward.

2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

At the time of this writing, DMHA is unsure of the Medicaid coverage or the status of any QHPs in the state. Therefore, there are no plans for monitoring access to services offered through QHPs and Medicaid.

3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.

At the time of this writing, DMHA is unsure of the Medicaid coverage or the status of any QHPs in the state. Therefore, no agency has been identified as responsible for monitoring access to mental/substance use disorder services by the QHPs.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

There is a well-established toll-free Consumer Service Line number for consumers to call to report complaints, compliments, and concerns. This is contracted to an independent site. A process is in place to ensure complaints/concerns are addressed by the provider/entity and monitored by DMHA staff. Calls and responses are routed based on severity, and providers are asked to respond within a designated timeframe. DMHA tracks and monitors the number and types of calls per provider. The toll-free number monitoring and follow up can be extended to include additional providers as needed.

5. *What specific changes will the state make in what is bought given the coverage offered in the state's EHB package?*

At the time of this writing, DMHA is unsure of the Medicaid coverage or the status of any QHPs and EHB package in the state. Therefore, there are no plans for changes in any EHB package at this time.

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D. Health Insurance Marketplace

Block Grant Application Instructions: *The Health Insurance Marketplace (Marketplace) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.*

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

- 1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?*

The state will work with a third party to monitor, evaluate, and make programmatic changes, if necessary, in the areas of outreach, eligibility determination, enrollment, and re-enrollment. There are several viable options to evaluate impact, with final determination pending how the system is designed. This has been done successfully in the current Indiana hybrid public assistance system through the Indiana Public Health and Assistance Ombudsman. In that program, quarterly and annual reports are provided for purposes of evaluation. The ombudsman participates on public assistance advisory committees, works with clients on a day-to-day basis, and has first-hand knowledge of the system's programmatic success.

- 2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?*

There are several viable options to evaluate impact, with final determination pending how the system is designed. The state may expand the public assistance ombudsman program to

include the Affordable Care Act's navigator program requirements as mentioned in the previous question (Question 1).

3. *How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?*

The Indiana Division of Mental Health and Addiction (DMHA) presently uses a portion of its Block Grant funds for provider performance on outcome measures. DMHA's previous contracts required that Block Grant funds were used after state and other funds. DMHA can easily return to that practice under the Health Insurance Marketplace as DMHA better understands it. In short, this office has the capacity to mandate, by contract language, the utilization of Block Grant funds.

4. *How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs and how will the state assist its providers in enrolling in the networks?*

The state will collaborate with the State Medicaid Agency in order to assess needs and provide assistance in linking CMHCs and QHPs. In addition, DMHA will work with the State Medicaid Agency to facilitate provider training either in person or webinars to ensure providers are informed about enrolling in networks.

5. *Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.*

In 2013, approximately 24% (19,500) of adults with serious mental illness (SMI) served by the state system are uninsured. In 2013, approximately 56% (19,200) of persons with addiction served by the state system are uninsured. Historically, around 95% of all youth with serious emotional disturbance (SED) have some type of insurance coverage, primarily Medicaid. The projection of youth with SED for 2013 remains at 5% (2,800) uninsured. These estimates are based on actual numbers of persons served with no health insurance in SFY 2012 and preliminary numbers for SFY 2013.

6. *Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.*

Numbers of uninsured persons in 2014 and 2015 will be dependent upon whether or not the state elects to expand the Medicaid program to persons up to 133% of the federal poverty guidelines. Assuming the state does not expand Medicaid, the percentages of uninsured persons served in each population (serious mental illness, addiction, and serious emotional disturbance) will likely remain the same as in the response to question 5 above and the numbers of uninsured persons served would increase by about 2% for serious mental illness and addiction, and increase by about 7% for serious emotional disturbance.

If the state elects to expand the Medicaid eligibility to 133% of the federal poverty guidelines, potentially 10% of adults and 5% of children served by the public mental health and addiction system will be in the category for purchasing health insurance through the Health Insurance Marketplace. All other persons served will be Medicaid eligible. The following table provides the projected numbers of persons in each population for 2014 and 2015 that will be Medicaid eligible or Uninsured/ Insured through the Health Insurance Marketplace.

Estimates for 2014 and 2015		Medicaid Eligible	Uninsured or Insured through Marketplace	Total Served
2014	SMI	74,120	8,554	82,674
2014	Addiction	49,402	2,855	57,109
2014	SED	31,803	3,726	35,529
2015	SMI	75,603	8,725	84,328
2015	Addiction	52,861	3,055	61,106
2015	SED	32,439	3,800	36,239

The state estimated these numbers based on the following assumptions:

- The percentages of persons served over the past three fiscal years whose income was at or below 133% of the federal poverty guidelines would remain stable.
- The total number of persons served in the future would continue to grow at the same rate as currently being experienced, meaning that expanded Medicaid will not automatically result in increased numbers of persons accessing the public mental health and addiction system.

7. *For the providers identified in Table 8 —Statewide Entity Inventory// of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.*

There are 25 community mental health centers (CMHCs) listed in Table 10 of the Uniform Reporting System tables (Table 8 for the Mental Health Block Grant implementation report), five of which are included in one of the three network entities listed and one of which is no longer in business. All 25 CMHCs are currently enrolled in the state's Medicaid program. There is one additional provider listed in Table 10, which is a health care facility that is also enrolled in the Medicaid program.

The Substance Abuse Block Grant (SABG) implementation report includes the same entities as reported in the Mental Health Block Grant (MHBG) implementation report plus an additional eight entities that provide specialized substance abuse treatment. Two of the eight specialized substance abuse treatment providers are enrolled in the Medicaid program. Including the 25 CMHCs, there are 27 Medicaid providers for substance abuse treatment services.

8. *Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.*

At this time, there are no plans to add providers receiving MHBG or SABG funds. DMHA anticipates that the number of DMHA-funded providers currently enrolled in the Medicaid program will remain the same in both 2014 and 2015. DMHA has been reaching out to free-standing addiction providers, which are not funded by Block Grant funds, to raise their awareness of health care reform and to guide them to resources which may help them in becoming viable to work with third party payers. These efforts will continue over the next two fiscal years. Free-standing addiction providers are being encouraged to become Medicaid-enrolled providers and/or to partner with existing Medicaid-enrolled providers.

There are several types of Medicaid-enrolled providers which include the following: Psychiatric Residential Treatment Facilities (15 providers); outpatient mental health clinics (354 providers); CMHCs (131 providers); and Health Service Providers in Psychology (271 providers). This list includes enrolled agency providers as well as individual enrolled providers. Indiana anticipates the same or greater number of enrolled Medicaid providers moving forward. DMHA will collaborate with the State Medicaid Agency and the Indiana

Department of Insurance to provide information and linkage to the appropriate sources to encourage providers who are not currently enrolled in Medicaid to do so.

E. Program Integrity

Block Grant Application Instructions: The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplace, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. *Does the state have a program integrity plan regarding the SABG and MHBG?*

The state Division of Mental Health and Addiction (DMHA) is a division of the Indiana Family and Social Services Administration (FSSA), which has a specific internal agency, FSSA Audit Services, who is responsible for fiscal auditing of FSSA programs and agencies. In addition, the State Board of Accounts (SBA) provides oversight and monitoring of Federal funds across Indiana state agencies.

2. *Does the state have a specific staff person that is responsible for the state agency's program integrity activities?*

No. Program Integrity is comprised of multiple components with checks and balances.

3. *What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:*

a. *Budget review;*

DMHA does not currently review provider budgets.

b. *Claims/payment adjudication;*

DMHA's funding distribution is based on allocation of funds to support individuals and services not covered by other funding sources, not specific services or individuals. Therefore, there is not a claims adjudication system on client or service level currently in place. However, to ensure compliance and good stewardship of Block Grant funds, FSSA and DMHA both have a contract and claims management tracking system with protocols for claim tracking and approval. Contract scopes of work (SOWs) are written with concrete measureable objectives and deliverables tied to funding. Claims are approved based on deliverables being completed. Multiple checks and reviews of deliverables and fiscal stewardship are in place. Quarterly meetings are used to review status and for monitoring expenditures and utilization. As noted in section e. below, a performance-based payment system is in place to ensure accountability for process and qualitative outcomes.

c. *Expenditure report analysis;*

DMHA does not currently review provider expenditure reports.

d. *Compliance reviews;*

As noted above, DMHA contracts include scopes of work with specific deliverables which are monitored when claims are submitted. FSSA Audit Services and the State Board of Accounts audit for compliance. FSSA Audit Services also monitors provider independent audits for compliance and conducts further audits as determined necessary. DMHA also requires all providers receiving federal or state funds to maintain separate accreditation by a national accreditation organization approved by DMHA (Joint

Commission, Commission on Accreditation of Rehabilitation Facilities, etc...). In addition, DMHA staff conducts site visits and desk reviews to monitor compliance with certification and contracting program standards. An external vendor is contracted to provide in-depth reviews of compliance specific to checking onsite records for consistency with data reporting and standard compliance.

e. Encounter/utilization/performance analysis; and

Indiana has a relatively mature process for monitoring performance of the mental health and addiction community-based system across the state. This process includes the monitoring of access/capacity (number of persons receiving services each month), employment/education, and criminal/juvenile justice involvement from the National Outcome Measures along with overall improvement in assessed needs and strengths and reduced substance use. This formal system ties a portion of Block Grant funds () to a pay-for-performance contract. Perception of care is also being monitored for both mental health and addiction services through the Mental Health Statistics Improvement Program survey and the Youth Services Survey for Families. Encounter data and utilization data are required reporting at the client level from all contracted providers for all clients (those with serious mental illness, or SMI; serious emotional disturbance, or SED; or substance use disorders, or SUD). These data are used to monitor stability in housing, social connectedness, retention, and use of evidence-based practices. Plans for 2014 -2015 include matching mortality data from the state health department to the mental health and addiction database in order to establish a mortality baseline from which to measure the effects of future programs such as integrated primary and behavioral health care.

f. Audits.

As noted above, DMHA contracts include scopes of work with specific deliverables which are monitored when claims are submitted. FSSA Audit Services and the State Board of Accounts audit for compliance. FSSA Audit Services also monitors provider independent audits for compliance, and conduct further audits as determined necessary.

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

Indiana uses a complex formula to allocate funds from all sources to providers who have contracts with DMHA for service delivery. DMHA contracts with community mental health centers, specialty addiction treatment providers, and networks of community mental health centers and addiction treatment providers. The allocation formula is applied to the specific providers (not the network). This formula includes several variables including census data, number of persons served data, and level of need distribution for the numbers served. Allocations are calculated at the fund center level (that is, Block Grant funds are separate from state general revenue funds, etc...) and the population level (for SMI, SED, and SUD). The CMHCs are required by Indiana Code (IC 12-7-40.6) and by contract to provide a

defined continuum of care. Continuum of care means a range of services, the provision of which is assured by a community mental health center or a contracted addiction treatment provider. The term includes the following:

- Individualized treatment planning to increase patient coping skills and symptom management, which may include any combination of the services listed under this section.
- Twenty-four (24) hour a day crisis intervention.
- Case management to fulfill individual patient needs, including assertive case management when indicated.
- Outpatient services, including intensive outpatient services, substance abuse services, and treatment.
- Acute stabilization services including detoxification services.
- Residential services.
- Day treatment.
- Family support.
- Medication evaluation and monitoring.
- Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty.

5. *How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?*

DMHA requires all providers receiving federal or state funds to maintain separate accreditation by a national accreditation organization approved by DMHA (Joint Commission, Commission on Accreditation of Rehabilitation Facilities, etc...). These organizations require providers to meet many standards including quality, health, and safety standards.

6. *How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?*

The state will work collaboratively with the Mental Health and Addiction Planning and Advisory Council to review and discuss Block Grant priorities to ensure Block Grant funds are spent appropriately per requirements. Each Block Grant priority workgroup will submit recommendations to DMHA leadership and the full planning council on key priority components to direct Block Grant funds in order to achieve priority area goals.

Recommendations will be used in the decision making process to ensure Block Grant dollars are used to meet the identified priority needs and fill identified gaps for which other funding is not available.

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

F. Use of Evidence in Purchasing Decisions

Block Grant Application Instructions: *SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:*

1. *Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?*

The state does not have a dedicated staff member to track and disseminate information on evidence-based or promising practices, though many staff members are well versed in evidence-based and promising practices for their respective areas of expertise. This information is shared via various channels including workgroup meetings, presentations, and conferences, via newsletters or the sharing of research publications, and the sharing of evaluation reports and performance data.

2. *Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?*

Yes, the state is committed to making decisions based on the use of data to inform best practices and purchasing/policy decisions. The Indiana Division of Mental Health and Addiction (DMHA) wishes to transition to the sole implementation of evidence-based practices. It will be required of grantees and contractors to implement pre-approved and reviewed evidence-based practices.

In addition, for SFY 2014, DMHA's Bureau of Mental Health Promotion and Addiction Prevention released a request for funding in which one of the requirements for the project was that the program or strategy chosen to be implemented be evidence-based according to the evidence-based criteria 1 and 2 set forth by SAMHSA for prevention strategies.

a) What information did you use?

During SFY 2012, DMHA released a request for proposals to fund evidence-based practices. Respondents proposed EBPs to address their target areas; these projects are currently in operation and are being evaluated. The outcomes of these projects will influence future funding decisions. Evaluation results from previous or current initiatives as well as research publications, national registries, federal guidance documents, and national cross-site evaluations have been used in decision-making regarding evidence-based practices. The Bureau of Mental Health Promotion and Addiction Prevention within DMHA frequently utilizes information from the National Registry on Evidence-based Policies and Practices and other national registries of effective prevention strategies when reviewing requests for funding and considers strength of fit in addressing the presenting risk and protective factors.

b) What information was most useful?

Information from national registries and publications was most helpful to determine “goodness of fit,” or how well a proposed strategy, if implemented correctly, would achieve the desired outcomes. Information from local-level evaluation reports and cross-site evaluations were most useful to understand potential implementation issues and local level needs.

3) How have you used information regarding evidence-based practices?

Evaluations of current and previous initiatives have helped the state determine what considerations need to be made prior to selecting or implementing a strategy and enabled the state to provide necessary training and technical assistance prior to and during implementation. DMHA is currently developing pre-approved lists of evidence-based practices that have been evaluated at the national level as well as consulting evaluation reports to determine the effectiveness of the local implementation of evidence-based practices. Training on evidence-based practices will be required and provided either through a train-the-trainer program or from curricula developers. DMHA is working to determine how to ensure ongoing fidelity monitoring. DMHA is currently receiving technical assistance from the Center for the Application of Prevention Technologies (CAPT) to develop fidelity tools for strategies being implemented across the state.

a) Educating State Medicaid agencies and other purchasers regarding this information?

DMHA has shared knowledge obtained from various sources including evaluation reports and other publications when possible at workgroup meetings, through funding announcements, conference presentations, websites, annual reports, and state strategic plans.

DMHA staff members are available to provide technical assistance to local and state providers on the selection and implementation of evidence-based strategies. DMHA also funds an addictions resource center to provide technical assistance to prevention and treatment providers on the selection and implementation of evidence-based practices.

b) Making decisions about what you buy with funds that are under your control?

DMHA is currently developing pre-approved lists of evidence-based practices that have been evaluated at the national level as well as consulting evaluation reports to determine the effectiveness of the local implementation of evidence-based practices. Training on evidence-based practices will be required and provided either through a train-the-trainer program or from curricula developers. DMHA is working to determine how to ensure ongoing fidelity monitoring. DMHA is currently receiving technical assistance from the Center for the Application of Prevention Technologies (CAPT) to develop fidelity tools to be shared with providers. Information regarding evidence-based practices is used as a scoring tool to evaluate proposals and influence funding decisions. Proposed strategies are evaluated for goodness of fit to address presenting risk factors. Process and outcome data are collected and evaluated to determine future funding initiatives.

G. Quality

Block Grant Application Instructions: Up to 25 data elements, including those listed in the table below will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use-Past 30 Days	Reduction/No Change in Substance Use-Past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/ Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections– Community Connections	Percent in Treatment employed, in school, etc... (Treatment Episode Data Set)	Clients w/ SMI or SED who are employed, or in school

1. *What additional measures will your state focus on in developing your State BG Plan (up to three)?*

Indiana is developing a new measure for community integration which will be tested during State Fiscal Year 2014 (beginning July 1, 2013). The measure is intended to monitor consumer progress toward recovery within the SAMHSA recovery framework of Home, Health, Purpose, and Community. This measure will be calculated separately for persons receiving substance abuse treatment services and persons receiving adult mental health services.

2. *Please provide information on any additional measures identified outside of the core measures and state barometer.*

The Community Integration measure will be calculated from 14 items on the Adult Needs and Strengths Assessment (ANSA) tool which has been adopted in Indiana as a standardized clinical assessment required of all providers that receive mental health/substance abuse treatment funds through the State Mental Health Authority (SMHA)/State Substance Abuse Authority (SSA). The ANSA is required at the beginning of a treatment episode, every six months of continuous treatment, and at discharge whenever possible. The specific items from the ANSA that will be included in the calculation are: Social Connectedness; Community Connection; Natural Supports; Resourcefulness; Social Functioning; Job History; Recreation; Family Functioning; Volunteering; Educational; Employment; Family Strengths; Spiritual/Religious; and Involvement in Recovery. Ratings for each item are averaged for Time 1 and Time 2. Improvement is defined as a difference between Time 1 and Time 2 equal to or greater than 3.46 (the reliable change index for this measurement). The target for this measure is 20% of consumers improved in community integration. The target will be the same for substance abuse treatment and for mental health treatment. The measure will be reported quarterly.

3. *What are your state's specific priority areas to address the issues identified by the data?*

Community integration is specifically related to the availability of recovery supports, appropriate housing, and integration of behavioral and primary health care, which are three of the priority areas being addressed by the State Mental Health Authority (SMHA)/State Substance Abuse Authority (SSA). Data provided by SAMHSA related to prevention will be incorporated in planning activities of the workgroup on prevention and mental health promotion as well as into the data utilized by the State Epidemiological Outcomes Workgroup.

4. *What are the milestones and plans for addressing each of your priority areas?*

These are available in Table 1 for each priority area.

H. Trauma

Block Grant Application Instructions: *In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.*

This office has added a new focus on military and military families, as the Division of Mental Health and Addiction (DMHA) participated in the SAMHSA-sponsored Service Members, Veterans, and their Families Policy Academy in May 2013. DMHA has a solid team assembled, and there are plans to expand that team. DMHA is fortunate to have the Star Behavioral Health Providers network providing training in military culture to providers across the state. The final stage of the Star training includes trainings on treatments that address specific military trauma-related issues such as post-traumatic stress disorder and traumatic brain injury. Additionally, one of DMHA's providers has started an endorsement process to designate those providers that have military competence. One of the short-term goals of the military coalition is to present to the directors of the Family and Social Services Administration the goals of this coalition and to include them as partners. There is also a plan to brief the Governor on this planning effort. DMHA is examining the sensitivity of its present assessment tools, the Child and Adolescent Needs and Strengths (CANS) assessment and the Adult Needs and Strengths Assessment (ANSA), in identifying military issues, including trauma to the service member or to the family. While changing the assessment tool cannot be done until next year, DMHA will develop a protocol for providers to ask more focused questions during the assessment period.

With the activities listed above, DMHA is in a good position to foster increased attention to the trauma experienced by the military and by their families and to better provide services that are acceptable to the military.

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure

therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

Since July 1, 2008, Indiana has incrementally implemented the use of comprehensive functional assessment tools for children, youth, and adults across public service systems (mental health providers, addiction services, child welfare, and Medicaid). The CANS and ANSA include an Adjustment to Trauma item in the Mental Health domain. In the comprehensive versions of these communimetric tools, Adjustment to Trauma screens for history of trauma exposure, experience, and related adjustment needs. An expanded trauma module is triggered by the Adjustment to Trauma item. The extension modules include history of trauma exposure and related needs consistent with post-traumatic stress disorder (PTSD). Additionally, the general Adjustment to Trauma item also identifies trauma related needs which fall short of PTSD, but which interfere with functioning and would benefit from intervention. DMHA, Medicaid, and child welfare policies require that the ANSA or a developmentally appropriate version of the CANS, including personal history of trauma and related needs, be completed at the beginning of services and reassessed every six months and at discharge.

Additionally, specific programs integrate trauma screening and trauma-informed care initiatives into their practice and protocol. For example, the Indiana Access to Recovery (INATR) grant includes a trauma screening item in the required Government Performance and Results Act (GPRA) assessment; recovery specialists also complete the ANSA.

INATR screens clients for trauma through the GPRA Client Outcome Instrument. INATR clients are asked a series of GPRA questions related to traumatic experiences they may have endured. These questions are required to be asked upon INATR program intake, follow-up, and discharge; however, it is not required that clients provide answers to the questions being posed.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

In July 2012, review of the frequency of identified trauma-related needs within the CANS found that 15-16% of youth with substantiated abuse or neglect had identified trauma adjustment needs by Department of Child Services (DCS) staff. In comparison, in SFY 2011, Indiana's community mental health and addiction providers identified trauma-related needs for 32% of children and youth in treatment. For youth receiving intensive community-based services through the Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) grant, 45.3% had identified trauma related needs (51.4% for the CA-PRTF youth with reported child welfare involvement). DMHA, DCS, the Indiana University (IU) CANS team, and the IU School of Social Work/DCS Training Partnership have worked together to build on efforts to help systems and services become trauma-informed and provide methods of referral for trauma-focused therapies. Some activities currently underway to promote education in trauma-informed care and training on trauma-focused cognitive-behavioral therapy (CBT) include the following:

- During SFY 2013, DCS, DMHA, community providers, and the IU CANS Technical Assistance Team worked with Dr. Cassandra Kisiel from the National Child Trauma Stress Network CANS Technical Assistance Center to enhance Indiana's CANS tool, improving the descriptions for trauma and other items to better identify and assess trauma-related needs.
- The IU-DCS training team is launching trauma trainings statewide for all DCS Family Case Managers (FCMs). Screening, assessment, and trauma-sensitive interventions are highlighted in the trainings.
- The IU CANS technical assistance team provided regional trauma-related CANS training during the spring of 2013. On-site training on trauma-informed care and using the CANS tools to screen and assess trauma were offered in 18 Department of Child Services regions with 1,376 participants from local child welfare offices.
- Online trauma-related training and technical assistance to reliably identify potentially traumatic events, experiences, and adjustment needs is offered through the Praed Foundation's CANS/ANSA training website, <http://www.canstraining.com>.
- A new workshop, Using CANS to Screen and Assess Trauma-Related Needs, was offered twice on July 25, 2013, to mental health providers and child welfare staff at the annual Indiana Council of Community Mental Health Centers Annual Children's Conference. The conference theme of becoming trauma-informed was well-received by over 300 conference participants.
- DCS is supporting training, certification, and implementation of evidence-based services, including developmentally appropriate trauma-informed treatment for residential and community-based providers.
- DMHA, through CA-PRTF sustainability funding from the Centers for Medicare and Medicaid Services (CMS), is sponsoring Trauma-Focused Cognitive-Behavioral Therapy for intensive youth service providers.

INATR consultants and providers are seasoned in the field of Recovery Support Services and routinely provide clients with referrals to a wide array of needed services including trauma-focused therapy when appropriate. INATR supports and promotes SAMHSA's trauma-informed care definition and principles through client referrals from INATR to trauma-specific interventions and trauma-focused therapy.

3. *Does your state have any policies that promote the provision of trauma-informed care?*

While specific policies currently do not exist to promote the provision of trauma-informed care, this type of care is encouraged through System of Care communities. For children and youth, the current focus is on training clinicians in community and residential agencies to provide evidence-based Trauma-informed Cognitive Behavioral Therapy. In March 2013, DMHA trained 50 providers throughout the state on trauma-focused CBT in partnership with the National Technical Assistance Center for Children's Mental Health.

INATR supports and promotes SAMHSA's trauma-informed care definition and principles through client referrals from INATR to trauma-specific interventions and trauma-focused therapy. Nearly one-third of the state's Recovery Consultants and Providers are licensed and trained clinicians who have expertise in treating victims of trauma.

4. *What types of evidence-based trauma-specific interventions does your state offer across the life-span?*

As resources to implement evidence-based trauma services are limited, a cross-system, state/provider approach is essential to improving access to effective trauma-related care by clinicians who are trained and certified in evidence-based trauma treatment.

The Indiana Department of Child Services has made this a priority and is sponsoring a series of trauma-based workshops statewide. Some local providers are hosting training and a path to certification in evidence-based trauma treatment.

5. *What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?*

Through the sustainability plan for the Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant, the state had a national trainer train 50 therapists on Trauma-Focused Cognitive Behavioral Therapy in March 2013. One Community One Family, the System of Care in Southeastern Indiana, has been working to develop a trauma-informed system and has offered workshops based on their experience. They understand that trauma-informed system transformation moves beyond simply implementing services to a

paradigm shift in how organizations interact with children and families. The project director, child welfare regional manager, and a parent with experience in the child welfare system have detailed the steps and strategies utilized by their local System of Care in working with child welfare to become trauma-informed by utilizing the Niatx Process Improvement Model. Their presentation is from a rural perspective and details the use of training, consultation, social marketing, evaluation, and ongoing technical assistance in not only implementing but also sustaining trauma-informed changes.

INATR recovery consultants and providers receive ongoing training on a wide array of techniques and evidence-based practices for provision of recovery support services in a Recovery-Oriented System of Care. Training in these areas is inclusive of trauma-specific interventions. During the past two years, the recovery consultants and providers have taken part in an event called Operation Immersion. This 2 ½ day conference provides briefings and seminars about the unique problems facing persons in the military and they deal with substance abuse disorders. The major theme of these presentations is the effects of trauma as a result of Post-Traumatic Stress Disorder. The presenters are practitioners who provide evidence-based practices that can be used in the field by the attendee.

I. Justice

Block Grant Application Instructions: *The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving court related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions, operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. 41,42 Rottman described the therapeutic value of problem-solving courts: “Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs.” Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed. A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention Please answer the following questions:*

1. *Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?*

In Indiana, an individual’s Medicaid benefits are terminated when the individual enters an institution. The Division of Mental Health and Addiction (DMHA) is working with sister agencies to reduce/eliminate the lag time between discharge from an institution to when Medicaid eligibility is re-established and benefits start. Otherwise, providers in the community are expected to assess and link individuals to entitlements including enrolling in

Medicaid. DMHA will work with the State Medicaid Agency to ensure behavioral health providers have all information necessary to assess, inform, and link individuals to benefits.

Recognizing that access to medical and mental health care is an essential element in successfully diverting youth from the juvenile justice system, the newly created position of Juvenile Detention Alternative Initiative (JDAI) Community Liaison will be working with local juvenile justice stakeholders to ensure that eligible youth are enrolled in Medicaid. The Indiana Department of Correction Division of Youth Services has recently created the position of JDAI Community Liaison and a second position will be added, with approximately six more positions to be added in 2013. The JDAI Community Liaison will be assigned to each region of the state and will work collaboratively with key juvenile justice stakeholders to reduce the reliance on secure detention; to facilitate placement of youth in their home communities, when placement is necessary; to work with communities to prevent at-risk youth from entering the juvenile justice system; to ensure that adjudicated youth have access to adequate services to prevent deeper penetration into the juvenile justice system; and to work with community corrections agencies to expand community alternative programs for at-risk youth.

2. *What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?*

Several counties/localities in Indiana have problem-solving courts and diversion programs aimed at identifying individuals who may benefit from treatment instead of incarceration. Indiana has promoted the use of Crisis Intervention Teams (CITs) and funded several communities to provide CIT training and implementation.

In addition, DMHA has a contract with the Indiana Department of Correction (IDOC) for the SOGS (South Oaks Gambling Screen) to be completed at intake on everyone in the Therapeutic Communities. Individuals who receive a score indicating they have a gambling problem receive education and community referral information for problem gambling services upon their release. Mental health assessments have been added to the process of intake evaluation at the Indiana Reception Diagnostic Center, which is a maximum-security intake facility for adult males sentenced to IDOC.

In 2006, Indiana implemented the Indiana Juvenile Mental Health Screening, Assessment, and Treatment Project which now impacts 17 of the 22 juvenile detention centers in the state. Through the project, detention centers administer the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) for all youth entering detention centers as a pre-sentencing tool. The remaining five detention centers are in various stages of implementing the MAYSI-2. The majority of the time, the MAYSI-2 is used in detention pre-sentence. Youth

who are then committed to the Indiana Department of Correction are also given the MAYSI-2, and this is done post-sentence.

3. *Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?*

A workgroup meets bi-monthly to discuss the management of offenders with serious behavioral health issues. Representatives from DMHA, IDOC, and other community organizations and advocates participate in this workgroup. A memorandum of understanding (MOU) is in place between various state agencies to identify potential offenders and complete all paperwork prior to reentry for the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families, and Medicaid as well as schedule appointments. There are challenges to this work being implemented as intended for those going through the reentry process. IDOC has a contract with Mental Health America of Indiana to provide ombudsman services to assist IDOC offenders in applying for benefits as their release date approaches.

In Indiana, the State Mental Health Authority (SMHA)/State Substance Abuse Authority (SSA) and other child/family serving agencies participate in the Indiana Juvenile Detention Alternatives Initiative (JDAI) State-wide Expansion. Currently, eight counties are involved with another eight counties scheduled to be added by 2014. Through JDAI, youth with mental and/or substance use disorders should be diverted from secure detention and referred to alternative programs.

4. *Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?*

As mentioned earlier, the IDOC Division of Youth Services has recently created the position of Juvenile Detention Alternative Initiative (JDAI) Community Liaison. Efforts related to enrollment and case coordination could be included in the work of the new JDAI Community Liaisons.

5. *What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?*

Through the abovementioned workgroup, trainings have been held on behavioral health disorders for jail and IDOC officers; on psychiatric medications for CITs; and on forensic psychiatry topics for judges.

Mental Health 101 and 201 training for criminal justice staff will be provided by the National Alliance on Mental Illness. The topic for the upcoming Mental Health and Criminal Justice Summit will be on reentry.

Cross-training efforts have been in place among some state-level agencies, such as: the Indiana Department of Correction, the Division of Youth Services of the Department of Correction, the Department of Child Services, and the Division of Mental Health and Addiction.

Corizon, which provides health care services for correctional facilities in Indiana, will be conducting trainings for parole officers on behavioral and mental health issues and suicide prevention. Training is also being developed for sheriffs, judges, and community health centers to learn about each other's systems.

J. Parity Education

Block Grant Application Instructions: SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. Please answer the following questions:

1. *How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?*

Indiana will utilize umbrella statewide mental health advocacy/public education organizations to develop a public education campaign that targets specific stakeholders, including consumers, families, providers, insurers, and the public sector. The targeted education will include educational materials and presentations, individual assistance and intervention, as well as social media. Included will be the capacity to monitor and intervene when appropriate, through coordination between the Division of Mental Health and Addiction (DMHA), the Indiana Office of Medicaid Policy and Planning (OMPP), the Indiana Department of Insurance (IDOI), and the Mental Health Ombudsman. Stakeholders will be informed as to who they can contact if they have questions or concerns.

2. *How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)?*

Indiana will utilize the Mental Health and Addiction Planning and Advisory Council (MHAPAC). A roster of the MHAPAC members can be found in narrative section W. MHAPAC will provide education and awareness to legislators, consumers, and advocates. This Council will be given the role of providing input regarding parity as to provide consistency within the public and private sectors.

3. *What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?*

Indiana will work in partnership with the State Medicaid Agency and IDOI to develop educational materials to educate communities and individuals about parity in Indiana. Educational materials will be disseminated consistent with a public education campaign developed with input from MHAPAC. Critical to this process is a clear understanding of what parity requires and how such is to be implemented and enforced. A process will be developed to review coverage decisions and respond to complaints by consumers. A part of the education process will be to develop access points for the grievance process.

K. Primary and Behavioral Health Care Integration Activities

Block Grant Application Instructions: Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects. Please answer the following questions:

1. *Describe your involvement in the various coordinated care initiatives that your state is pursuing?*

The Division of Mental Health and Addiction (DMHA) is involved in meetings with the State Medicaid Agency regarding exploration of health home implementation. A team from Indiana including DMHA was invited to participate in a national meeting co-sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the Centers for Medicare and Medicaid Services (CMS) to learn about health homes. DMHA has worked with the State Medicaid Agency and behavioral health providers as a consultant in reviewing proposals for the development of health homes. DMHA has a strong behavioral health/primary care integration initiative with five sub-committees; Health Homes is one of those sub-committees. Indiana is exploring options and may move forward with the submission of a Health Home State Plan Amendment (SPA), which will address needs of individuals with behavioral health issues.

2. *Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?*

Yes. DMHA is involved in internal and external stakeholder meetings regarding duals (individuals who are Medicaid/Medicare eligible). Indiana opted to not participate in the duals demonstration project. Instead, Indiana is exploring other options to improve access, coordination of service, and manage costs across the dual population, as well as the aged, blind, and disabled population.

3. *Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?*

Yes. Primary and Behavioral Health Care Integration is a priority initiative for DMHA. DMHA has partnered with the State Medicaid Agency and Indiana Department of Health to lead a stakeholder group to move integrated care to scale in Indiana. The primary care association and community mental health center association are actively involved in the integration work spearheaded by this stakeholder group and five subcommittees. The focus of the integration work is targeting federally qualified health centers, community health centers, rural health centers, and community mental health centers. The stakeholder group is composed of these groups as well as a wide range of other public health/behavioral health stakeholders including but not limited to consumers/families, universities/researchers, and SAMHSA integration grantees.

4. *Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.*

DMHA addresses nicotine dependence within the contracts for DMHA-funded providers. There is a dedicated section to a tobacco-free workplace which coincides with the drug-free workplace clause in DMHA's standard boilerplate contracts. See the language from the boiler contract below:

Tobacco-Free Workplace Certification.

The Contractor hereby covenants and agrees to make a good faith effort to provide and maintain a tobacco-free environment.

Under the terms of this Contract, Tobacco is defined as all products that contain tobacco, which may include: cigarettes, cigars, chewing tobacco, pipes and all smokeless tobacco products.

The Contractor certifies and agrees to provide a drug-free workplace by:

- A. Establishing policies and procedures which, at minimum, include the following items:
- a. Defines the tobacco-free environment as the facility, grounds and all vehicles located on the Contractor's property;
 - b. Establishes the inclusion of all consumers, staff, contractors, volunteers and visitors in the tobacco-free policy;
 - c. Requires that all consumers, staff, contractors, volunteers and visitors be informed of the tobacco-free policy;
 - d. Establishes screening, education and treatment programming for consumers, staff, contractors and volunteers; and
 - e. Establishes procedures to address violations of the tobacco-free environment policy.

- B. Including a screen for tobacco use and tobacco dependence of consumers as part of the initial and ongoing assessment process. Findings shall be noted in a consumer's clinical record.
- C. Incorporating tobacco dependence treatment into the treatment planning process.
- D. Incorporating education specific to tobacco dependence into clinical programming. Such education may be included in current patient education programming, such as substance education, HIV and other health-related education.
- E. Offering or allowing FDA-approved tobacco treatment medications for use by consumers.
- F. Giving contractor staff, volunteers and contractors access to tobacco dependence education.
- G. Making a good faith effort to maintain a drug-free workplace through the implementation of subparagraphs (1) through (6) above.

A performance improvement report is submitted annually to demonstrate the decrease in consumers reporting tobacco use by county.

- 5. *Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.*

The DMHA State-Operated Facilities (SOFs) are tobacco-free. The SOFs screen patients via the referral packets to ensure patients are tobacco-free prior to admission. The SOFs have supports in place to assist patients and staff such as tobacco-free education, patches, and medication.

- 6. *Describe how your behavioral health providers are screening and referring for:*
 - a. heart disease, b. hypertension, c. high cholesterol, and/or d. diabetes.

Indiana has a wide range of integration approaches being used. Some behavioral health providers have embedded primary care physicians or nurse practitioners within the behavioral health settings to assess for and treat common health issues. Others have purchased and/or become certified/accredited by the Health Resources and Services Administration as federally qualified health centers (FQHCs) or FQHC look-alike entities providing a wide range of health services and behavioral services for consumers and the community. Others have collaborative reciprocal agreements with local community health centers and FQHCs to provide care to shared consumers. DMHA has conducted a survey to ask this question to better assess who/how/how many providers are doing health screenings and has received responses from over 60 behavioral health and primary health care providers. An analysis of the data has not yet been conducted at this time, but the survey results are attached to this Block Grant application.

L. Health Disparities

Block Grant Application Instructions: *In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.*

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

The health disparity gap among racial and ethnic minorities continues to widen within Indiana as the state becomes more racially and ethnically diverse. The Division of Mental Health and Addiction (DMHA) has worked toward addressing this issue by partnering with several state and local organizations to assess data collection. The State Epidemiological Outcomes Workgroup is currently creating supplements to the annual report to focusing on the LGBTQ, re-entry, and veterans populations. Grant opportunities have also been made to provide prevention services to traditionally underserved populations such as LGBTQ, older adults, and non-English speakers. DMHA will continue coordinating efforts with its partners and stakeholders to develop a strategy to decrease or eliminate health disparities of racial, ethnic and underserved populations through integrated health care, mental health promotion, and prevention services

1. *How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?*

DMHA will track access or enrollment, types of services received and outcomes by race, ethnicity, gender, and age through its in-house data collection system. The state has started discussions regarding the addition of LGBTQ data elements to the community mental health and addiction services database. DMHA will work on developing and implementing a plan to include these data elements.

2. *How will you identify, address and track the language needs of disparity-vulnerable subpopulations?*

DMHA will explore mechanisms for the development of a tracking tool to identify, address and track the language needs of disparity-vulnerable subpopulations.

3. *How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?*

The Division of Mental Health and Addiction will partner with the Indiana Minority Health Coalition, Indiana State Department of Health and other local agencies to develop and implement plans to address and seek to reduce health disparities among vulnerable subpopulations.

4. *How will you use Block Grant funds to measure, track and respond to these disparities?*

DMHA utilizes Block Grant funds to fund a staff member that is responsible for addressing the Behavioral Health services and needs of vulnerable subpopulations including but not limited to minorities, individuals with co-occurring physical challenges, LBGTQ, veterans, older adults and those with traumatic brain injury. Tracking services for these groups is not completely included in the current data set, but DMHA will examine the collection of these data.

M. Recovery

Block Grant Application Instructions: SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. *Has the state developed or adopted (or is the state in the process of developing and or adopting) a definition of recovery and a set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?*
Yes
2. *Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the behavioral health system.*
Yes
3. *Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant directed care?*
Yes
4. *Does the state's plan indicate that an array of recovery supports and services that meet the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports include a mix of services outlined in the Good and Modern Continuum of Care Service Definitions, including: peer support; recovery support coaching; recovery support service centers; supports for self-directed care; peer navigators; and other recovery supports and services (e.g., warm-lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, respite care, etc.).*
Yes
5. *Does the state's plan include peer delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, families/significant others?*

Yes

6. *Does the state provide, or support training for the professional workforce on recovery principles and recovery-oriented practice and systems including the role of peer providers in the continuum of services?*

Yes

7. *Does the state have an accreditation program, certification program or standards for peer-run recovery centers?*

No

8. *Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services; identification and dissemination of best practices in recovery supports/services; other innovative and exemplary activities that support the implantation of recovery-oriented approaches and services within the state's behavioral health system.*

The Indiana Certified Recovery Specialist (CRS) Program has successfully trained 240 consumers of services as peer support specialists since the initiation of the program on July 1, 2009. Currently 116 of those CRS's have maintained their certification, with 47% being employed as peer support specialists throughout the state.

The Division of Mental Health and Addiction (DMHA) has dedicated funds to support consumer-operated businesses (COBs). The first offering in SFY 2011 supported three COBs. Based on those successes the State is currently dedicating \$500,000.00 each year in SFY 2013 and SFY 2014 for the operation and support of COBs.

The State continues to fund the Office of Family and Consumer Affairs (OFCA). The OFCA continues to be a conduit for the community to reach DMHA leadership. This office also functions as the center of Priority Area #2, Recovery Supports, as defined in the Block Grant application.

DMHA is actively supporting the community to develop alternatives to State-Operated Facility admissions. Grants were awarded in SFY 2014 to community mental health centers (CMHCs) to improve community-based recovery supports to divert consumers from requiring state hospital stays and to allow them access to community-based environments.

During SFY 2013, DMHA supported local CMHCs with funds from the Block Grant to support evidence-based practices (EBPs). Each CMHC was given the opportunity to solicit funding by submitting a proposal for an EBP. DMHA awarded grants to each CMHC to support those EBP proposals.

DMHA continues to support KEY Consumer Organization, Inc. KEY is the State-supported consumer organization. KEY provides many exemplary supports, such as Wellness Recovery Action Plan trainings; Warm-Line, a peer-support phone line; additional peer support services; and support groups. KEY plays an important role in decision-making by being present on the Mental Health and Addiction Planning and Advisory Council (MHAPAC), the Indiana Consumer Council (ICC), and the Recovery Supports Workgroup (RSW).

The National Alliance on Mental Illness (NAMI) is supported financially by DMHA. NAMI is able to provide families and consumers much needed support. NAMI provides family-to-family and peer-to-peer service and an annual conference among many other supports.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, states should consider the following questions:

- 1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?*

The Division of Mental Health and Addiction (DMHA) has always included family and consumer participation in planning. The predecessor of the Block Grant application, the 99-660 state plan (1991), included family members and consumers.

Individuals in recovery and their family members are recruited to be members on several influential boards and councils. Consumers are participating as members of the Priority Area #2- Recovery Supports Workgroup. Consumers and families are members of the Mental Health and Addiction Planning and Advisory Council. DMHA maintains a series of advisory boards, including but not limited to the Children's Advisory Board, the Access to Recovery Advisory Committee, and the Indiana Consumer Council. Consumers and families make up the majority of the membership of these bodies, and their input and direction influence DMHA's direction.

During SFY 2013, surveys of providers, consumers, and family members were completed for several areas of DMHA's services and programs, including surveys for the Access to Recovery program as well as surveys created by the Priority Area #2 Recovery Supports Workgroup. Although these surveys were primarily related to priority areas of the Block Grant application, DMHA was also able to gather community feedback and input on the effectiveness of behavioral health services.

The Bureau Chief for the Office of Family and Consumer Affairs will contact consumers and families and set meetings to discuss and review proposed policies before implementation when appropriate. For example, DMHA began to explore options for the implementation of a peer workforce. The Bureau Chief for the OFCA held 36 meetings throughout the state with various stakeholders to measure community support for the initiative.

2. *Does the state sponsor meetings or other opportunities that specifically identify individuals and family member's issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?*

The four Block Grant priority area workgroups provide opportunities for individuals and family members to specifically identify issues and address needs. The four areas cover: Housing, Recovery Supports, Prevention, and Primary Care and Behavioral Healthcare Integration. DMHA facilitates multiple committees and advisory boards with the aim to address community needs in the behavioral healthcare system.

The Bureau Chief for the Office of Family and Consumer Affairs acts as the state's liaison to the Indiana Consumer Council. This council is recognized as a part of DMHA. Recently a consumer-operated business grant in the amount of \$50,000.00 was awarded to the council to conduct a public awareness campaign to reduce stigma and promote treatment.

DMHA operates the Consumer Service Line, which is a toll free phone service for members of the public to formally address concerns, provide feedback, or file complaints.

DMHA regularly conducts surveys of consumers to solicit input and gather feedback on satisfaction with services. The Annual Consumer Readiness Assessment Survey, which is completed by state hospital patients, is being improved to include recovery-oriented themes to better gauge consumer input on barriers to discharge and on what actions are necessary to remain out of the state hospital.

3. *How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?*

DMHA actively engages community organizations to engage users of services and the people who support them in activities to address improving the delivery system. The National Alliance on Mental Illness (NAMI) of Indiana and its local affiliates provide the consumers and families opportunities to proactively involve themselves in the decision making process. KEY Consumer Organization reaches out to the consumers of services with opportunities to participate in the Indiana Consumer Council. KEY provides funding support for travel to consumers to attend all of DMHA's meetings and related conferences and trainings. KEY teaches the Wellness Recovery Action Plan (WRAP) system in efforts to assist consumers to direct their care when needed. Indiana's Medicaid Rehabilitation Option Plan supports person-centered planning. DMHA supports consumer-operated businesses that are recovery-based, consumer-driven activities.

The number of CMHCs employing Certified Recovery Specialists (CRS's) continues to grow. One role filled by the CRS is to educate and assist consumers to self-manage their care and treatment. This includes helping the consumer to become knowledgeable to complete treatment plans and set recovery goals.

Community involvement in shared decision-making is being promoted through DMHA partners. NAMI affiliates, KEY Consumer Organization and CRS's in the CMHCs are educating users of services on the use of Advanced Psychiatric Directives, WRAP plans, Illness Management and Recovery, and Whole Health Action Management.

4. *How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?*

In general, DMHA supports a large number of community organizations to purposefully assist in strengthening and expanding its efforts. Through ongoing contact with a large number of DMHA staff, community-based programs can access resources that provide the most up to date innovations in recovery-oriented care. DMHA, using funds from the Block Grant, has funded eight consumer-operated Businesses with the intent of assisting consumers in expanding their support networks by providing friendly environments, peer-run centers, and training in WRAP and Whole Health Action Management (WHAM).

DMHA's support of NAMI makes it possible to bring family-to-family and peer-to-peer courses to many communities in Indiana. In SFY 2013, NAMI was able to conduct 124 Connection support group meetings, 104 family support group meetings, two family-to-family education courses, and 18 In Our Own Voice presentations.

Affiliated Service Providers of Indiana (ASPIN) has been DMHA's partner for the last four years in the delivery of Indiana's Certified Recovery Specialist (CRS) Program. To date, ASPIN has successfully trained 240 consumers of services as CRS's. At the time of this writing, 47% of those who responded to a recent survey (N=66) are employed as CRS's in community organizations.

KEY Consumer Organization, Inc. is the state's consumer-run organization. DMHA provides support through an annual grant and by ensuring that KEY members are major contributors to policy development and planning meetings. The executive director of KEY has a seat on the state's Legislative Mental Health Commission and the Mental Health and Addiction Planning and Advisory Council (MHAPAC). The Bureau Chief for DMHA's Office of Family and Consumer Affairs fills the role of liaison for the Indiana Consumer Council which is facilitated by KEY and other community representatives. Mental Health America of Indiana (MHAI) is a contributor to DMHA's policy development activity. This is a reciprocal relationship as the executive director of MHAI presides over MHAPAC.

Housing

- 1. What are your state's plans to address housing needs of persons served so they are not served in settings more restrictive than necessary?*

In SFY 2013, the Division of Mental Health and Addiction (DMHA) offered Indiana's community mental health centers the opportunity to apply for Block Grant funds to expand and enhance services directly aimed at diverting consumers of services from inpatient admissions and reducing lengths of stay in state hospitals. The centers were expected to build infrastructure and services to support individuals in their community and include plans to sustain programs that would permanently reduce the number of consumers who would be admitted to inpatient services.

DMHA is supporting the development of peer-run wellness centers and peer-run respite centers. Two peer-run wellness centers are already operating, and a peer-run respite center is in the process of being founded. The peer-run wellness centers focus on providing community supports, including formal peer support, to assist persons to access needed services that increase the likelihood of being able to remain in the community. The peer-run respite center will provide a viable option for consumers to access short respite stays in a peer-supported environment with a strong focus on utilizing the most unrestrictive environments.

DMHA also supports housing first initiatives. Through collaboration among community partners and other state agencies, independent housing choices are being offered to persons in

need. This housing is truly “housing” and is not connected to services. However, any person using this housing has ready access to services should they request them.

2. *What are your state’s plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?*

The Indiana Certified Recovery Specialists are, among other things, tasked with the challenge to assist consumers to identify and maintain natural community supports. This includes finding persons and places that are supportive and conducive to healthy community living.

DMHA has a strong working relationship with the Indiana Housing and Community Development Authority (IHCDA), which contracts with the Corporation for Supportive Housing. The two agencies have offered a series of trainings called the Supportive Housing Institute in which providers, funders, and housing providers come as a team from localities to develop plans for housing. For many treatment providers, this is the first exposure to such cooperative planning. IHCDA has submitted a grant application for increased Section 811 supportive housing funding that is closely linked to DMHA and its contracted providers.

DMHA is exploring the increased utilization of supportive housing. A survey being conducted at this writing is identifying many providers that have adopted this model. This survey includes asking DMHA providers about who owns the lease and the keys to housing and if treatment compliance is linked to the housing. An apartment owned or leased by the provider and sublet only to compliant consumers is not the housing model DMHA is promoting. Along with that DMHA is looking at changing the present utilization of group homes and other congregate living programs. Many providers are decreasing their reliance on group homes.

N1. Prevention

Block Grant Application Instructions: *As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.*

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

- 1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?*

The State Epidemiological Outcomes Workgroup (SEOW) produces an annual epidemiological profile of consequence and consumption data in Indiana gathered from various data sources to aid policymakers, communities, providers, prevention professionals,

and other related parties to make informed decisions to address mental health promotion and substance abuse prevention. Upon review of the 2011 State Epidemiological Report, the SEOW discussed the need to reassess the priority substances and targets through 2017. After analyzing available data on risk and protective factors, substance use, and consequences, the SEOW determined four priorities and set objectives to reduce use in these areas by 2017. The main factors considered in determining the priority areas were which substances affected the largest number of Hoosiers (including substances with the highest rates of use), as well as whether trends indicated an increase in use of a certain substance. State readiness to address the priorities was also considered. The four substance abuse prevention priorities for 2012 to 2017 were determined to be alcohol, tobacco, prescription drugs, and marijuana. Baseline information, referring to the current percentage of reported use, was determined by reviewing the Indiana rates from the most recent year available from national surveys such as the National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS). Targets, the goal percentages of reported use to be reached by 2017, were determined by reviewing the criteria set forth in [Healthy People 2020](#), a product of the U.S. Department of Health and Human Services that provides structure and guidance for improving the nation's health as well as 10-year goals and actions steps to achieve various health outcomes. The SEOW established the following priority areas and targets through 2017:

I. ALCOHOL – REDUCE UNDERAGE AND BINGE DRINKING

1. Reduce past-month alcohol use among 12- to 20-year-olds
Baseline: 23.6% (95% CI: 21.0-26.3) (NSDUH, 2009)
Target: 21.2%
Target setting method: 10% improvement (Healthy People 2020, objective SA-13.1)
2. Reduce past-month binge drinking among 12- to 20-year-olds
Baseline: 17.0% (95% CI: 14.8-19.3) (NSDUH, 2009)
Target: 15.3%
Target setting method: 10% improvement (modified from Healthy People 2020, objective SA-14.1)
3. Reduce past-month binge drinking among 18- to 25-year-olds
Baseline: 40.8% (95% CI: 37.0-44.8) (NSDUH, 2009)
Target: 36.7%
Target setting method: 10% improvement (modified from Healthy People 2020, objective SA-14.2)

II. TOBACCO

1. Reduce past-month smoking among adults

Baseline: 21.2% (95% CI: 19.9-22.5) (BRFSS, 2010)
Target: 18.0%
Target setting method: ITPC, Strategic Plan 2015 (p. 32)

2. Reduce smoking among pregnant women

Baseline: 18.5% (Indiana Maternal and Child Health Outcomes and Performance Measures Data Book, 2007, p. 87)¹
Target: 12.0%
Target setting method: ITPC, Strategic Plan 2015 (p. 32)

III. PRESCRIPTION (Rx) DRUGS

1. Reduce past-month nonmedical use of prescription pain relievers² among high school seniors

Baseline: 6.6% (ATOD, 2011)
Target: 5.9%
Target setting method: 10% improvement (SEOW consent)

2. Reduce past-month nonmedical use of prescription drugs (excludes prescription pain relievers) among high school seniors

Baseline: 5.9% (ATOD, 2011)
Target: 5.3%
Target setting method: 10% improvement (SEOW consent)

IV. MARIJUANA

1. Reduce past-month marijuana use among 18- to 25-year-olds

Baseline: 16.5% (95% CI: 13.6 – 19.8) (NSDUH, 2009)
Target: 14.8%
Target setting method: 10% improvement (SEOW consent)

2. Reduce past-month marijuana use among 12th grade students

Baseline: 19.8% (ATOD, 2011)
Target: 17.8%
Target setting method: 10% improvement (SEOW consent)

¹ Because of birth certificate revisions, the 2007 tobacco data are not strictly comparable with data from prior years.

² Includes Vicodin, OxyContin, Percocet

In November 2011, Indiana received a SEOW program contract to support the integration of substance abuse prevention and mental health promotion efforts and to expand the focus of the SEOW's work. As part of the grant, the state sought to identify new high-risk populations, specifically those believed to be at high risk but about which not much is known. These discussions resulted in the identification of four new high-risk populations: veterans returning from the wars in Afghanistan and Iraq; offenders and the re-entry population, LGBTQ individuals; and individuals with dual diagnosis (co-occurring mental and substance use disorders). A supplement to the 2012 State Epidemiological Report, profiling these four populations, will be published in September 2013. The supplement will provide an overview of what is known about these specific groups in terms of their mental health and substance use patterns and offer suggestions for expanding efforts to monitor change in and improve prevention services for these populations as well as increase data collection efforts. These populations, as well as Latino populations, have also been identified by SAMHSA as being at higher risk for substance use and mental disorders. The SEOW designed a survey to gain knowledge of health issues affecting the LGBTQ population. The survey, which was administered in 2012 in an online format, acquired over 300 responses. The results of the survey will be published in the supplemental report in September 2013 and used to address the prevention and mental health promotion needs of this population in the future.

The Indiana Prevention Resource Center (IPRC) conducts the Survey of Alcohol, Tobacco, and other Drug Use among Indiana Youth and Adolescents (ATOD Survey) annually. The survey includes items to measure not only consumption, but also risk and protective factors. The ATOD Survey collects the National Outcomes Measures (NOMS) as well as items adapted from the Communities That Care (CTC) Survey to measure risk and protective factors. The result is a table representing the percentage of youth statewide considered to be high risk/low risk on the following CTC domains: community, family, school, and peer-individual. This item is also provided to counties, school corporations, and individual schools to assist local level providers with their assessments and strategy selection. A version of the ATOD Survey also exists for the college population and is known as the ICAN (Indiana Collegiate Action Network) or College Survey. In addition to the ATOD and ICAN Surveys, the IPRC produces county profiles utilizing Geographic Information System (GIS) data to provide the state and local providers with a better picture of the risk and protective factors as well as resources in their community. All applicants for funding must submit an implementation plan demonstrating how the proposed strategies match to the risk and protective factors in the community informed by local level data. A primary goal of the Division of Mental Health and Addiction (DMHA) is to enhance the quality of data collected throughout the state by analyzing ways to increase participation in and use of results from the ATOD and College Survey as well as additional means to collect adult level data.

2. *What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?*

The Division of Mental Health and Addiction is committed to funding quality prevention services in a fiscally prudent manner, as there are currently few state funds dedicated to primary prevention in Indiana. In the 2013 legislative session, House Bill 1328 was passed providing resources to schools at the elementary and high school level to increase social services offered to children and parents including substance abuse prevention. Funds have yet to be allocated by the State Board of Accounts, though it is anticipated this will bring an additional \$500,000 per year of state funding to increase prevention activities. The Bureau of Mental Health Promotion and Addiction Prevention has created reporting methods to ensure that services are not funded through other means. All applicants requesting SABG funds must describe current funding streams including other federal and state grants. Applicants must describe how the activities in the proposal are significantly different than those being funded by other sources. A statement is also included in each request for proposal describing supplanting; each applicant must attest that the proposed activities are not supplanting current funding. The review committee may disqualify applicants who cannot adequately distinguish that they are not supplanting or blending funding streams. The bureau is also partnering with the Indiana Criminal Justice Institute to create a map of all substance abuse prevention services funded through various streams to analyze activities provided as well as saturation. The map will be completed by August 2013.

Funded initiatives are also subject to additional monitoring throughout the grant cycle. Financial reports are submitted quarterly detailing expenses as well as other funding mechanisms. An effort is also made to ensure that grantees who may also be receiving other federal funds, (e.g., the Sober Truth on Preventing Underage Drinking Act Grant (short title: STOP Act Grant) or the Drug Free Communities Support Program grant) are not blending strategies/initiatives. If questions arise as to whether the same activities are being charged to separate federal grants DMHA will contact the grantee and the grantee's evaluator for further clarification to determine whether activities will be reimbursable with Block Grant funds. The following list represents current funded initiatives that are anticipated to continue as well as planned initiatives that are in development:

Current Initiatives (SABG Funds):

- Prenatal Substance Use Prevention Program (PSUPP), Indiana State Department of Health: Supports community grants across the state for the program Baby and Me: Tobacco-Free or other evidence-based perinatal addiction prevention strategies.
- Leading and Educating Across Domains (L.E.A.D.) Initiative, Geminus Corporation

(RFP 9-83): Creates community networks of youth leaders who are trained in and help implement programs among their peers to deliver prevention messages.

- L.E.A.D. expansion to 10 additional sites, Geminus Corporation (RFP 9-83 Amendment).
- Elder L.E.A.D., Geminus Corporation (RFP 9-83 Amendment): Variation of the original youth version of L.E.A.D. intended to be a peer prevention program for older adults. This initiative has completed a statewide needs assessment of the behavioral health and substance abuse prevention needs of older adults and begun forming partnerships with organizations serving seniors.
- Addiction technical assistance center, the Indiana Prevention Resource Center at Indiana University-Bloomington (RFP 9-42): Provides technical assistance and training for prevention and treatment providers across Indiana, and offers in-depth technical assistance for DMHA-funded prevention providers.
- Indiana Coalition to Reduce Underage Drinking (ICRUD), Mental Health America of Indiana: A statewide organization that focuses on advocacy, networking, and other strategies to prevent and reduce underage drinking. ICRUD is responsible for promoting, developing, and administering the Indiana College Survey and works with college campuses across the state, among other initiatives, to help prevent underage drinking.
- State Alcohol Compliance (SAC) Program, Indiana Alcohol and Tobacco Commission/Indiana State Excise Police: Provides training and compliance checks for alcohol retailers across the state.
- Indiana State Epidemiological Outcomes Workgroup (SEOW), Indiana University-Purdue University at Indianapolis (RFP 9-43): Is responsible for collating and analyzing data to identify trends, priorities, and goals for substance abuse and mental health in Indiana.
- Family Prevention Pilot Program, five primary contractors (RFF 2012-01): Community-based grantees implementing evidence-based, family-based prevention programs.
- Development Grantees, nine primary contractors (RFF 2012-02): Community-based grantees utilizing the Strategic Prevention Framework and Communities that Care system to develop and enhance a coalition and create a strategic plan for their community.
- Pilot Grant Program to Implement Community Strategic Plans, 11 primary contractors (RFF 2012-03): Community-based grantees utilizing the Strategic Prevention Framework and previously created strategic plans to implement effective prevention strategies in their community.

Current initiatives (non-Block Grant Funds):

- Type II Gaming Compliance, Indiana Alcohol and Tobacco Commission/Indiana State Excise Police: Monitors and performs compliance checks for licensed gambling establishments.

- Synar/Tobacco Retailer Inspection Program (TRIP), Indiana Alcohol and Tobacco Commission/Indiana State Excise Police: Provides compliance checks and monitoring for tobacco retailers in Indiana.
- Implementation of the Strategic Prevention Framework-Partnerships for Success II Grant to reduce prescription drug abuse in Indiana. (five community level contractors and the Indiana Professional Licensing Agency)
- Indiana Problem Gambling Awareness Program, Indiana Prevention Resource Center at Indiana University-Bloomington: Provides training, technical assistance, and resources to providers across the state regarding problem gambling prevention, awareness, and treatment.

Planned Future Initiatives (SABG funds):

- LGBTQ youth substance abuse prevention initiative, Indiana Youth Group
- Army National Guard prevention training and outreach initiative, Indiana National Guard
- Cohort 2 Grants to Implement Community Strategic Plans, Contractors TBD
- Re-entry prevention initiative, Indiana Department of Correction/Community Coalitions
- Prevention Prepared Communities, Contractors TBD
- Statewide campus substance abuse prevention initiative, Contractors TBD, proposed contractors include Ivy Tech Community College and Indiana University and Purdue University regional campuses

3. *How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?*

The Division of Mental Health and Addiction (DMHA) recently completed a five-year strategic plan to enhance the prevention system in Indiana. The strategic planning process enabled DMHA to identify needs in the Indiana prevention system. Systemic logic models were created to inform the enhancement of the priority areas. Indiana's three determined priority areas are to enhance the prevention workforce, to enhance the delivery of services, and to enhance data and evaluation. Workforce development is of the utmost importance to the Indiana prevention system. With workforce as its number one systemic enhancement priority area, DMHA envisions a culturally responsive, dynamic, professional prevention workforce committed to continuous professional development through the leveraging of technical assistance and training resources from local, state, and national experts/agencies. DMHA plans to fulfill this vision by meeting the following four objectives: 1.) establish minimum state criteria for prevention credentialing, certification, and core competencies; 2.) establish a sustainable statewide training system to support core competency development; 3.) establish a consistent technical assistance delivery system; 4.) increase access to training and technical assistance.

DMHA is also offering capacity-building grants known as development grants.

Development grantees are local coalitions that have received funding to undergo the strategic planning process and formulate a plan for implementing strategies in order to prevent the use of alcohol, tobacco, and other drugs. Their efforts must be based on local needs and strengths and will focus on reducing certain risk factors associated with use and enhancing factors that will protect against use. Grantees will also practice intensive efforts in community mobilization and coalition development so that their communities will have the capacity to carry out their plans in the future. Development grantees will be trained in the Strategic Prevention Framework (SPF) and the Communities That Care system and will be expected to follow both processes as they develop their plan.

DMHA is in the preliminary stages of designing a resource development plan to infuse basic prevention training throughout the state in partnership with the Indiana Criminal Justice Institute (ICJI). The plan will be designed with input from the Prevention Workgroup Committee and the Mental Health and Addiction Planning and Advisory Committee membership in consultation with the Center for the Application of Prevention Technologies. Anticipated content for statewide prevention training includes prevention basics, overview of SPF and the six strategies, selecting appropriate evidence-based strategies, comprehensive proposal development, effective budget development, community mobilization and coalition maintenance, environmental strategies, and so on. DMHA and ICJI have a shared goal to increase the knowledge of basic prevention fundamentals of coalitions and providers statewide to enhance the quality and effectiveness of prevention services implemented and to leverage resources to create a coordinated and consistent training effort.

4. *What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?*

The state anticipates collecting the NOMS data as well as outcome measures created by the developer of each strategy being implemented. Process data will also be collected from grantees to determine what factors may have influenced implementation and program outcomes. Currently data is being collected through reports submitted electronically through Qualtrics and SurveyMonkey by each grantee monthly. Efforts during 2012-2013 to develop an online data repository through KIT Solutions were unsuccessful. DMHA is currently working with a local developer to create an online data repository and evaluation system to provide Indiana with more expedient access to outcome and process data. It is anticipated that this system will be fully functional and accessible to all grantees by January 1, 2014. It is imperative not only to evaluate the effectiveness of local-level initiatives, but also to continuously monitor progress made at the state level. The strategic planning process has enabled DMHA to identify priorities, goals, and objectives for the state as set forth in this plan. In order to meet these priorities, however, a systematic approach consisting of both

process and outcome evaluation must be taken. DMHA will seek an outside evaluator to create an evaluation plan that will include measurable criteria and benchmarks based on the priorities set forth in this strategic plan. DMHA will provide the evaluator with quarterly progress updates to be compiled into an annual report. The evaluator will highlight accomplishments as well as areas needing improvement.

5. *How is the state's budget supportive of implementing the Strategic Prevention Framework?*

Indiana is committed to expanding the SPF process to coalitions and communities throughout the state. In collaboration with prevention specialists from the Indiana Prevention Resource Center, the state of Indiana has created the Community Prevention Framework (CPF) as a guide for Indiana communities as they undertake prevention efforts and move through the SPF process. CPF combines elements of the latest research in prevention science, the SPF, and the Communities That Care (CTC) system.

DMHA plans to support communities to carry out the SPF process as part of the CPF by offering two major types of grants to communities or coalitions that want to engage in prevention efforts. The first, development grants, will be made available to fund communities and coalitions to complete a strategic planning process. With support from the Indiana Prevention Resource Center, development grantees will be trained in SPF and CTC, and will use these to guide their planning and identify community resources. DMHA currently dedicates \$900,000 towards the CPF development initiative.

The second set of grants that will be offered to communities are implementation grants. Communities under these grants already have a strategic plan. They may have used CTC or the SPF process in the past to create a plan, or they may be communities that are targeting special populations or implementing special projects, such as family-based prevention initiatives or targeting high risk populations. These communities will work with the Indiana Prevention Resource Center (IPRC) to update their strategic plans using the most recent local data, determine whether the selected strategies are the best fit to meet the priorities identified in the community, implement programs, and develop process and outcomes evaluation plans. Like the development grantees, these grantees will use the milestones and benchmarks from CTC to track progress and guide technical assistance needs as they carry out the SPF process.

As a result of being guided by the CPF, communities will have a strategic plan that addresses needs that were prioritized by the use of local-level data and includes evidence-based strategies that can be implemented to produce measurable outcomes and community-level change. A localized strategic plan will give a community a clear vision of what should be done to reduce substance abuse and mental illness and their consequences, and will unify the community in moving towards healthy living for everyone.

6. *How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)*

Approximately 36.6% of the prevention set-aside funds statewide prevention projects such as the IPRC, the SEOW, compliance inspections, PSUPP, the Coalition to Reduce Underage Drinking, and the L.E.A.D./Elder L.E.A.D. Initiative. The remainder of the funds currently goes to community organizations either to build local capacity and create strategic plans, to implement local strategic plans, or to implement family-based prevention programs.

7. *How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.*

The following programs and strategies are currently being implemented by grantees who have received implementation funding for strategies identified in local strategic plans and funding for family-based prevention programs, representing \$1,654,755 of the prevention set-aside:

Guiding Good Choices (4 counties)
Strengthening Families (3 counties)
Strengthening Families Program-Kumpfer
Strengthening Families Program 3-5 Kumpfer
SAMHSA Mental Health First Aid (3 counties)
Social Hosting Policy
Retailer Compliance
Policy change for increased enforcement
Big Brothers, Big Sisters Mentoring
Life Skills (2 counties)
All Stars Afterschool Programming
Children in Between
My Student Body
The Ripple Effect
Social Emotional Learning Activities for After School and Summer Programs
Too Good for Drugs
New Beginnings

Project Alert (2 counties)
Above the influence
Environmental Management Model
Active Parenting of Teens: Families in Action
Too Good for Drugs and Violence
Family Connections Parents in Partnership
Question Persuade Refer Gatekeeper Training
Children in the Middle
Nurturing Parenting Program
Keepin' it Real

The Afternoons R.O.C.K. program was an evidence based afterschool prevention program that was funded during SFY 2013 at \$2,227,812. Since the program completed its final year, those funds were made available via a competitive RFF process to support evidence based programs and environmental strategies at the local level for SFY 2014. Awards have yet to be made and contractors and specific activities are to be determined. Due to a reduction in Block Grant funding the amount available was reduced to \$1,630,762. Originally, it was anticipated that 100% of these funds would go to local providers to implement evidence-based strategies; however upon reviewing the applications received it was apparent that more resources needed to be devoted to infusing the state workforce with basic prevention fundamentals. DMHA plans to use a portion of the funding for statewide training efforts during SFY 2014 and will allocate these dollars for local implementation in SFY 2015.

N2. Evidence-Based Prevention and Treatment Approaches for the MHBG (five percent of funds)

Block Grant Application Instructions: *States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.*

DMHA will administer funds for evidence-based prevention and treatment approaches via the RFF (request for funding) process. The RFF process is used frequently by DMHA to receive competitive proposals and allows DMHA a greater level of flexibility than a traditional request for proposal process. Contracts and grants management personnel within the Family and Social Services Administration have created templates to structure the content of the proposal and work with section chiefs to ensure the RFF meets the needs of the intended program. Once the RFF document has been revised it will be released publically via a variety of channels including the following: e-mail announcements to various list serves, mailing lists, stakeholder groups, and consumer-operated businesses as well as via the Mental Health and Addiction Planning and Advisory Council membership and posting to the DMHA website. Typically, a public meeting will be held at the Indiana Government Center within a week of the posting of the grant announcement. This meeting serves as a pre-bidders conference to clarify goals and expectations as well as answer any questions from potential providers. Questions regarding the announcement are generally accepted in writing for an additional week and all responses will be published to the DMHA website. All applications will then be reviewed by committee and evaluated based on previously established criteria.

O. Children and Adolescents Behavioral Health Services

Block Grant Application Instructions: *Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.*

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification. Please answer the following questions:

- 1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?*

The Division of Mental Health and Addiction has supported the development and expansion of System of Care (SOC) throughout the state for the past decade. Nearly 80% of Indiana's 92 counties received financial support and technical assistance from DMHA to build SOC infrastructure and encourage partnership with youth-serving organizations in the community. Many of these SOC's are now regional (multi-county) collaborations. DMHA monitors deliverables of all funded SOC sites to ensure progress toward a building a strong governance board, community presence, referral system, and access to services by children and families.

DMHA, through its Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) Demonstration Grant from the Centers for Medicare and Medicaid Services

(CMS), has developed an extensive network of access sites. Each access site serves as a means to disseminate information to the field about local, state, and federal funded intensive behavioral health services available to assist in maintaining seriously emotionally disturbed youth within their home and community; and also provides a means for families to explore their youth's eligibility for those services. DMHA's goal is to have an established access site for each SOC area or region in Indiana (Indiana currently has 52 access sites). The presence of an access site in a county has allowed for elements of SOC to be recognized. As part of the CA-PRTF sustainability plan, DMHA has submitted an application to CMS for a 1915(i) State Plan Amendment to continue providing intensive community based wraparound services to eligible children and families. The 1915(i) has an anticipated start date of fall 2013 pending approval from CMS. The 1915(i) utilizes the same Access Sites to allow eligible children/families access to services.

DMHA has a Children's Advisory Board consisting of representatives from family groups, youth groups, child advocates, mental health and substance use providers, and other state agencies serving children and families. A role of this Board is to guide DMHA initiatives, including the future of SOC's across the state.

One Community One Family (OCOF), the SOC in the southeastern region of Indiana, is in the fifth year of its Children's Mental Health Initiative (CMHI) cooperative agreement. A provider survey by OCOF indicates that the community continues to move toward a better understanding, appreciation of, and adherence to SOC values. OCOF is partnering with DMHA and Department of Child Services (DCS) to pilot the Children's Mental Health Wraparound Services Project and is working with DCS to implement ongoing trauma-informed system transformation efforts. One agency partner in One Community One Family, United Families, has served over 40 families in parent-to-parent support. United Families is working with their community mental health center to provide a substance abuse group for parents involved with DCS. This group has helped to improve retention in substance abuse services by over 40%.

In partnership with DCS and the Indiana chapter of NAMI (National Alliance on Mental Illness), DMHA has been awarded funding from SAMHSA for the Expansion of the Comprehensive Community Mental Health Services for Children and their Families (Short Title: System of Care Expansion Planning Grant). The goals for Indiana under this grant include: 1) the establishment of a state-level SOC governance board (to include those with expertise in mental health and substance use/addictions for children and adolescents) that will provide the leadership, policy initiative and technical assistance needed to support communities in the development and sustainment of their local system of care; 2) endorse a single, statewide understanding and definition of a comprehensive, effective, behavioral

health SOC for youth and families; and 3) develop a strategic plan with long and short-term goals for expanding the state's SOC.

2. *What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?*

With individualized care planning at the forefront of wraparound practice and a value of SOC, DMHA has strengthened its commitment to individualized care for children and adolescents. DMHA is in the process of implementing a Wraparound Practitioner Certification Program throughout the state, in partnership with The Innovations Institute from the University of Maryland. Currently, DMHA is working with nearly 200 providers and supervisors statewide. Through training, coaching, and technical assistance, DMHA seeks to ensure that all providers working with children and families are providing standard, high-fidelity wraparound practice, of which individualized care is fundamental. DMHA will monitor compliance to wraparound practice and fidelity through evaluation of providers and supervisors using tools such as the COMET (Coaching Observation Measurement for Effective Teams), STEPS (Supportive Transfer of Essential Practice Skills) and CREST (Coaching Response to Enhance Skill Transfer) tools developed for use in the Wraparound Certification Program. DMHA will encourage providers who have not yet participated in the Wraparound Practitioner Certification Program to develop all plans of care for children in full partnership with the child and family at the onset of treatment, when a change in treatment is required, or yearly; utilize evidence-based practices for providing services to youth with mental, substance use, and co-occurring disorders; and promote resilience and recovery in the form of plans to attain educational and employment goals (when applicable) written into the plan of care.

3. *How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?*

As mentioned earlier, there is membership on the Children's Advisory Board from various state agencies serving children and families, including the Department of Child Services (DCS) and the Office of Medicaid Policy and Planning. The DMHA Bureau Chief for Child and Adolescent Services serves on many internal and external workgroups and advisory boards to share input and gather information from the ground-level to better enhance the delivery of service and educational needs.

DMHA facilitates a planning committee focused on awareness and education efforts around SAMHSA's annual Children's Mental Health Day. This planning committee is comprised of representatives from the Indiana Department of Education, the Indiana State Department of

Health, Mental Health America of Indiana, Section of Adolescent Medicine at the Indiana University School of Medicine, the Indiana Association for Infant and Toddler Mental Health, Indiana Center for Children and Families, and the Riley Hospital Child Development Center. Last year this planning committee secured a proclamation from the Governor for Children's Mental Health Awareness Week, produced a 30 second public service announcement about children's mental health, and hosted an open house for children's mental health month. Indiana also became recognized as a chapter of Youth MOVE (Motivating Others through Voices of Experience) National. As a chapter, Youth MOVE Indiana will be working with agencies such as child services, juvenile justice, education, and behavioral health providers to identify and engage young people in an initiative to make a difference in youth-serving organizations.

DMHA also has ongoing awareness and education efforts through the Indiana Coalition to Improve Adolescent Health, which provides mini-grants to local, community-based organizations to implement projects that not only engage youth, but also focus on the topics of suicide prevention, prescription drug abuse, bullying, stress, depression, and binge drinking.

DMHA has been assisting DCS with their recent initiative to fund mental health services for children and families meeting specific eligibility criteria without the requirement of having an open DCS case and going to court. This initiative is specifically targeting families that do not have access to services because they lack a funding source. DCS is implementing this initiative statewide through the DMHA established access sites.

4. *How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?*

During SFY 2012, pilot projects were launched in six Indiana counties which utilized five family-based prevention programs. Given the positive response to the projects, the family-based prevention programs continued through SFY 2013 and will be expanded for SFY 2014. DMHA intends to increase the budget for training and education initiatives statewide with an emphasis on providing statewide training to community partners in prevention programs that may address both behavioral health and addictions such as *Strengthening Families*, *Guiding Good Choices*, and *Children in the Middle*.

DMHA wishes to transition to the sole implementation of evidence-based practices. It will be required of grantees and contractors to implement pre-approved and reviewed evidence-based practices. DMHA is working in conjunction with the Department of Child Services to review and endorse particular trauma-informed care practices that are evidence-based. Training on evidence-based will be required and provided either through a train the trainer

program or from curricula developers. DMHA is working to determine how to ensure ongoing fidelity monitoring.

5. *How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?*

The Bureau of Mental Health Promotion and Addiction Prevention within DMHA is currently working with a local developer to create an online data repository and evaluation system to provide the state with more expedient access to outcome and process data. Previous efforts during 2012-2013 to develop an online data repository through KIT Solutions were unsuccessful. The ideal system will allow the state to track, in real time, direct services to youth as well as attendance, pre and post survey data, outcomes, and expenditures for service. Once a system is developed and ready for use, funded providers will receive training in the use of the system, and non-funded providers will be encouraged to report data. It is anticipated that this system will be fully functional and accessible to all grantees by January 1, 2014. The system will be evaluated for potential use by providers in domains other than prevention such as treatment and mental health.

On September 30, 2012, Indiana completed a five-year Medicaid grant to demonstrate that intensive community-based services are effective for youth with complex behavioral health needs. These are youth who might otherwise receive treatment in a psychiatric residential treatment facility (PRTF). In addition to traditional Medicaid clinical and rehabilitation services, facilitators coordinate additional grant services using the wraparound process. Non-traditional grant services include: habilitation (skill development), clinical consultation, family training and support, respite, flex funds, and non-medical transportation.

Behavioral health services are also provided statewide to youth and families with a wide range of mental health and substance use needs. The following paragraphs describe how Indiana has and will continue to monitor and track service utilization, costs, and outcomes for children and youth with complex mental, substance use, and co-occurring disorders.

DMHA tracks utilization of intensive youth services through Medicaid claims reports for program management, evaluation, and quality improvement. Claims data are also used by the Medicaid fiscal agent to compare the utilization and costs of intensive community-based and PRTF services for youth. For all DMHA funded services, providers also submit services data through the Data Assessment Registry for Mental Health and Addictions (DARMHA). Furthermore, Indiana has a Medicaid Quality Improvement subcommittee that monitors behavioral health services for youth from a cross-system perspective; participants include Medicaid, managed care, DMHA, service providers, the state child welfare agency, Indiana University, and other stakeholders.

The DMHA controller monitors funding and costs for youth behavioral health, substance abuse, and prevention services. The DMHA Children's Team also closely monitors the cost of intensive youth services. Medicaid officials track Medicaid expenditures. Additionally, child welfare refers youth with mental health and addiction needs to Medicaid providers and tracks their costs for youth services. The State Budget Agency monitors cross-system expenditures, supporting collaboration among child service agencies.

Indiana measures outcomes through several assessment tools that include the Child and Adolescent Needs and Strengths Assessment (CANS), Youth Satisfaction Survey (YSS), Youth Satisfaction Survey – Families (YSS-F) and the Wraparound Fidelity Index 4.0 (WFI-4). Indiana uses the CANS to monitor reliable improvement in functioning, behavioral health symptoms, risk behaviors, youth strengths, and caregiver strengths and needs as well as in specific areas (e.g., school functioning and criminal justice involvement). The YSS-F assesses overall satisfaction of families with usual community based services; for intensive youth services, the YSS is added. Due to evidence that close adherence to the wraparound model is related to positive outcomes, WFI surveys are completed with caregivers, youth, and facilitators periodically. Outcome, satisfaction, and fidelity data are used to monitor progress and improve services. Additionally, all DMHA contract providers report National Outcome Measures for each youth.

DARMHA collects outcome data for multiple state agencies and providers. For all funded treatment providers, DMHA provides outcome reports from CANS data at the child, clinician, and provider levels. For contracted mental health and addiction providers, a percentage of the federal/state DMHA allocation is based on outcome performance measures. Providers receive quarterly outcome performance reports, but can also run outcome performance reports at any point in time. Other state agencies that use the CANS can also run outcome reports. For example, a CANS Outcome Report at end of services is one measure of well-being for the state child welfare agency.

P. Consultation with Tribes

Block Grant Application Instructions: SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

*For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall **not** require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.*

The total American Indian/Alaskan Native population in Indiana is 0.3%. A portion of the 0.3% American Indian/Alaskan Native population is made up of the Miami Nation of Indiana. The Miami are not a federally recognized tribe. Legislation was previously introduced in the 2011 session of the Indiana General Assembly to confer state recognition on the Miami Nation but the bill died in committee without receiving a hearing. Senate Bill 342 was introduced in the current session to grant state tribe recognition to the Miami Nation; as of January 8, 2013, the bill was referred to the Committee on Public Policy for further review.

The Pokagon Band of Potawatomi Indians is a federally recognized tribe of 3,150 members. The land held by the tribe in federal trust is all located in Michigan, and the tribal government is located in Dowagiac, Michigan. The tribe considers the Pokagon Homeland to be made up of four counties in southwest Michigan and six counties (LaPorte, St. Joseph, Elkhart, Starke, Marshall and Kosciusko) in northwest Indiana.

The Pokagon own and operate the Four Winds Casino Resort in New Buffalo, Michigan, and the new Four Winds Casino in Hartford, Michigan. The Pokagon Band Behavioral Health Services is licensed by the State of Michigan to provide outpatient counseling for mental health and substance abuse. Due to the tribal government and services being based in Michigan, the Indiana Division of Mental Health and Addiction (DMHA) has not had a relationship with the Pokagon Band of Potawatomi Indians.

However, DMHA has identified the proper contact in the Pokagon tribal government and will be initiating contact in August 2013 to ascertain the willingness of the tribe to consult in the ongoing development of the Block Grant application. Additionally, this could include invitations to participate as a member of the State Epidemiological Outcomes Workgroup (SEOW) or the Mental Health and Addiction Planning and Advisory Council (MHAPAC). The Prevention Bureau Chief has requested technical assistance from the Center for the Application of Prevention Technologies regarding consultation and engagement of tribes as well as attending trainings and webinar series held by the Native American Center for Excellence.

Q. Data and Information Technology

Block Grant Application Instructions: *In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:*

- *Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;*
- *List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;*
- *Provide information regarding its current efforts to assist providers with developing and using EHRs;*
- *Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and*
- *Identify the specific technical assistance needs the state may have regarding data and information technology.*

Please provide an update of your progress since that time.

1. *Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;*

Client-level data were reported to the National Association of State Mental Health Program Directors Research Institute (NRI) for SAMHSA in December 2011, April 2012 and December 2012. The two required files are now programmed and can be generated and submitted at any time. The major challenge that Indiana has encountered is editing of previously submitted client-level information. These edits can change the data that has been submitted in the basic client information (BCI) file requiring the state to replace the files. The community database was completely redeveloped and implemented on July 1, 2009. For the past 3½ years, the state has worked with the providers to cleanse the data thus allowing changes in data from past years. This cleansing has included closing episodes of care that have been open with no activity for long periods of time, removing records that are duplicates, and ensuring that the data elements are correctly entered into the database. NRI and SAMHSA prefers that states not send replacement files since the process is intended to simply update those previous records that need to be updated. The state continues to work with the providers to ensure accurate and complete data and anticipates that submission of updated BCI files (as opposed to replacement BCI files) should become routine by December 2013. The Treatment Episode Data Set (TEDS) required for addiction consumers is being provided to the SAMHSA contractor.

2. *List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;*

The Data Assessment and Registration Mental Health and Addiction (DARMHA) and the Web Infrastructure for Treatment Services (WITS) systems are the same as described in the 2012 – 2013 Block Grant. The redeveloped DMHA Certification and Licensure Database using a web interface was deployed in September 2012. This database contains provider information for each entity which is certified or licensed by the State Mental Health Authority (the Indiana Division of Mental Health and Addiction, or DMHA).

In the 2012 – 2013 Block Grant, the state hospital database (Avatar) was discussed. That database contains the basic client information and some of the clinical record. The needs to fully integrate pharmacy/medication management data with the clinical record and to have a fully electronic medical record has resulted in a decision to replace the Avatar system with one that will meet the state's needs for state hospital clinical records. The pharmacy system will be fully implemented by August 1, 2013, and the new medical record system is expected to be fully implemented by July 2014.

3. *Provide information regarding its current efforts to assist providers with developing and using EHRs;*

Of the 33 substance abuse treatment providers, nine are stand-alone entities and 24 are community mental health centers. Eight stand-alone substance abuse treatment providers and one community mental health center that provides substance abuse treatment do not have electronic health records.

The state continues to offer consultative assistance to the providers without an EHR. The stand-alone substance abuse treatment providers do not qualify for the federal financial incentives and do not have the resources to purchase a system.

4. *Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and*

As stated in the 2012 – 2013 Block Grant, “If the State is required to pay providers on a fee-for-service basis, significant changes to the State's data, financial, and contractual infrastructures will be necessary. If the requirement includes knowing the funding source for each service/payment, the magnitude of the infrastructure changes expands exponentially. Infrastructure change of this magnitude will be very time consuming, human resource intensive and expensive. Any such changes would affect the state data system as well as the data systems run by each provider of services.”

5. *Identify the specific technical assistance needs the state may have regarding data and information technology.*

There are currently ongoing discussions in DMHA regarding the need for technical assistance for data and information technology. At this time, no specific needs have been identified.

R. Quality Improvement Plan

***Block Grant Application Instructions:** SAMHSA expects states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The state's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your state's current CQI plan for FY 2014-2015.*

The full Division of Mental Health and Addiction (DMHA) Continuous Quality Improvement Plan is attached to this Block Grant application.

The DMHA Quality Assurance Management Program is designed to maintain a system of continuous quality improvement so that care and services for children and adolescents, families, and adults including the elderly contribute to positive life outcomes. The goals are achieved through planned, accountable, and systematic performance improvement activities.

The continuous quality improvement (CQI) process was implemented in February 2012. The process selection of performance and critical outcome measures for this state fiscal year was made from a comprehensive list of data being collected and reported. DMHA identified and prioritized performance and critical outcomes measures that best matched the health and mental health and addiction system for the state.

The CQI process entails the following components: (1) identified goals, (2) performance indicators, (3) target date, (4) date of completion, (5) stakeholders, (6) identification of gaps/barriers, (7) trends and (8) next steps. Each program and priority area has the opportunity to modify and or adjust their goals and timelines. DMHA developed a standardized template that will be distributed to each program and priority area to complete and submit on a quarterly basis to the Quality Assurance committee. The CQI process will allow for the Plan, Do, Check, Act

(PDCA) cycle to occur. The implementation of PDCA will allow for continuous evaluation of activities, and ensure that services, to the extent possible, reflect their evidence of effectiveness.

Process for Responding to Critical Incidents, Consumer Service Line and Grievances

DMHA has an internal review team that is comprised of representatives from Provider and Community Relations, Certification / Licensure, Office of General Counsel and other DMHA staff as deemed appropriate. There are designated staff members to monitor provider compliance with recommendations and expectations. For any situations that require additional monitoring, DMHA has the option to request the contracted vendor to conduct on- site reviews for compliance.

The process for responding to critical incidents, provider complaints, and grievances is outlined below:

DMHA requires providers to complete a critical incident report of individuals who receive mental health and addiction services.

1. Once the provider completes the critical incident report it is sent to DMHA's secure fax.
2. The report is then logged in a data base and forwarded to the Provider and Community Relation Liaison who will review the case.
3. In the event that a determination is made for follow-up, an internal fact-finding review is required.
4. The Provider and Community Relation Liaison will work with the Certification/Licensure team to formulate an action plan and identify any violation of the rules.
5. The case is then assigned to a Liaison who will work directly with the provider.
6. The Liaison staffs the case with the internal team regarding action taken and response.
7. The providers will receive a summary of the findings.
8. If it is deemed that there is no evidence of violations of licensure or certification standards, then DMHA's response is reviewed by the team and sent to the provider.
9. The critical incident report data is collected and aggregated on a quarterly basis to analyze trends by type of incident and populations.

Process for Complaints/Consumer Service Line

1. DMHA contracts with an outside vendor to manage the process flow of consumer complaints. They are responsible for routing the complaint to the appropriate entity.
2. After careful review, a determination is made about whether the complaint can be addressed through an internal fact-finding process. In the event that additional information is required, an in- depth on-site visit will be scheduled through the agency's contracted vendor.

3. If a concern is substantiated through the fact-finding process, an action plan is formulated with the agency. On an as needed basis, efforts will be coordinated with the certification/licensure team. Any further follow-up will be reviewed with the supervisor.
4. If it is deemed that there has been no violation of licensure standards, certification standards, and/or contractual requirements, then DMHA's response to the provider and complainant is finalized.
5. A copy of all correspondence from the Complaint/Consumer Service Line call is filed.

DRAFT

S. Suicide Prevention

Block Grant Application Instructions: *In the FY 2012/2013 Block Grant application, SAMHSA asked states to:*

Provide the most recent copy of your state's suicide prevention plan; or
Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at

http://www.samhsa.gov/grants/blockGrant/docs/SAMHSA_State_Suicide_Prevention_Plans_Guide_Final.pdf.

The Indiana Division of Mental Health and Addiction (DMHA) is interested in building an integrated and collaborative network of community organizations and state agencies to focus on suicide prevention and awareness. In late 2009, DMHA, in conjunction with the Indiana State Department of Health (ISDH), used the following methods to gather information about suicide prevention and awareness efforts in the state, as well as identify any gaps in services: an electronic survey of providers and key stakeholders; a review of current ISDH statistics regarding suicide; a key stakeholder summit; and a review of additional research available at the state, local and national level.

In early 2010, DMHA conducted a “State of Suicide” survey. The goal of the survey was to create a snapshot of current suicide prevention and intervention services in the state. The respondents included individuals from K-12 schools, higher education, state offices, clergy, medical, mental health, military, law enforcement/correctional, family-focused services, advocacy organizations, and suicide-focused programs. The two largest groups responding were K-12 education and organizations associated with mental health/addiction. The survey was sent to 1,428 persons and forwarded to at least 365 more respondents. The estimated response rate was 42% with 751 responding (382 full and 369 incomplete responses).

Upon completion of the survey, DMHA and ISDH identified key stakeholders to convene a Suicide Prevention Summit to review and clarify the survey results, discuss the gaps in services and future needs for suicide prevention activities.

From this summit, key stakeholders were identified for the Indiana Suicide Prevention Advisory Committee. The committee has continued to hold meetings since its late 2010 inception. They reviewed and analyzed several state suicide prevention plans as well as national strategies to discuss and select features that could be used in Indiana’s suicide prevention plan. This

information, along with the findings of the survey and summit, were the framework for Indiana's plan. The Indiana suicide prevention plan was completed and printed in September 2012 along with a brochure. Roll out of the state plan occurred during Suicide Prevention Awareness Week, September 9-15, 2012. In October 2012, the plan and brochure were presented to the Mental Health and Addiction Planning and Advisory Council (MHAPAC). The state plan was well received and unanimously adopted. A website was also created at <http://www.in.gov/issp/>, where an electronic copy of the *Indiana State Suicide Prevention Plan* and other resources are available. A copy of the Indiana State Suicide Prevention Plan is also attached to this Block Grant application. The plan will continue to evolve and be updated. The Indiana Suicide Prevention Advisory Committee will continue to meet and evaluate the suicide prevention efforts, activities and needs to ensure the plan stays current.

In 2011, the Indiana Legislature passed a bill making great strides for suicide prevention training in Schools. Indiana House Bill 1019 and Indiana Senate Bill 4 became effective July 1, 2011. This bill requires the Division of Mental Health and Addiction to consider evidence-based programs and develop programs for teacher training on the prevention of child suicide and the recognition of signs that a student may be considering suicide. It also allows a governing body to adjourn its schools to allow teachers to participate in a basic or in-service course of education and training on suicide prevention and the recognition of signs that a student may be considering suicide. Additionally, it states that after June 30, 2013, an individual may not receive an initial teaching license unless the individual has completed training on suicide prevention and the recognition of signs that a student may be considering suicide.

DMHA and the Suicide Prevention Advisory Committee have partnered with the Department of Education and Indiana State Department of Health to vet a comprehensive best practices suicide prevention training list for current and future teachers. The list was completed in spring 2013 and is posted on DMHA's suicide prevention website as well as the Department of Education website.

During the coming year and beyond, the Suicide Prevention Advisory Committee will be diligently working on marketing and outreach strategies for implementing the new state suicide prevention plan. The committee has begun outreach efforts to existing community action groups throughout the state and has helped spur interest and support for new groups. The committee is also planning an Indiana Suicide Prevention Summit to be held on September 10, 2013, to provide key community stakeholders with information, education and resources (including the state plan) for suicide prevention activities. In addition, the committee is seeking opportunities to present the new state plan and current efforts of suicide prevention at conferences, meetings, and trainings for identified key stakeholders.

T. Use of Technology

Block Grant Application Instructions: *In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:*

- *What strategies the state has deployed to support recovery in ways that leverage ICT (Interactive Communication Technology);*
- *What specific application of ICTs the State BG Plans to promote over the next two years;*
- *What incentives the state is planning to put in place to encourage their use;*
- *What support system the State BG Plans to provide to encourage their use;*
- *Whether there are barriers to implementing these strategies and how the State BG Plans to address them;*
- *How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;*
- *How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and*
- *What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.*

States must provide an update of any progress since that time.

Updates to the 2012-2013 Block Grant Application

Two new consumer-operated businesses are being funded with Mental Health Block Grant funds in SFY 2014 to further explore the use of Interactive Communication Technologies by persons with serious mental illness or co-occurring addiction disorders. The first of these will be a project that explores the use of social media as a recovery support. The funds will support bringing peers together for the purpose of combating isolation and promoting wellbeing through socialization. The other project will implement shared decision making and partnership building between peers and their providers. It will utilize the Common Ground program developed by Dr. Pat Deegan.

The 2013 Indiana General Assembly passed legislation that clarifies and expands the use of telemedicine for Medicaid members. This new legislation has the potential to expand the usage of this technology for persons with mental illness or addiction disorders as the technology becomes more prevalent for Medicaid members.

2012 – 2013 Block Grant Text

M. Use of Technology

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care and recovery support services. ICTS are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, e-therapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, videos, case manager support and guidance, telemedicine. In the space below, please describe:

- a. *What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?*

Using Transformation Transfer Initiatives (TTI) funding, DMHA facilitated a series of trainings that focused on delivering training and information regarding recovery oriented care using Interactive Webinars and e-learning. In addition, during May and June 2011, DMHA leadership utilized videoconferencing to conduct needs assessments to assess recovery oriented care implementation and barriers with sample (10) community providers.

DMHA changed policy/procedures for SOF gate keeping beginning SFY 2012 to allow use of ICTs for alternating contacts to be used for continuity of care meetings with consumers and SOF treatment teams without express written permission from DMHA. However, consumers must be asked and agree to the use of this type of technology.

DMHA contracts with the Indiana Prevention Resource Center (IPRC) for several prevention/promotion programs and activities and the Indiana Problem gambling Awareness Program. IPRC has employed the following strategies: Websites, Listserv, Webinar, E-Learning, Skype (monthly), SurveyMonkey, Hot Rods Evaluation Program, Geo-coded data for program planning, online college drug and gambling behavior survey.

- b. *What specific application of ICTs does the State plan to promote over the next two years?*

In partnership with OMPP, DMHA will continue to assess and update policy/procedures/rules to support use of ICTs for consumers care and provider support as deemed appropriate.

The IPRC plans to promote: Annual Alcohol, Tobacco, Other Drug, and gambling behaviors survey to be administered online (over 200,000 IN students 6th – 12th grade), and increase webinars and distance learning education to provide more trainings.

DMHA is exploring opportunities to use web-based access to problem gambling inquiries, Based on the success of this initiative, DMHA will use experience gained to determine where and how to expand these activities.

Webinars and video conferencing will continue to be used as a means to communicate information, conduct training, and engage stakeholders in meeting participation.

c. What incentives is the State planning to put in place to encourage their use?

In partnership with OMPP, will support reimbursement and rule revisions for services delivered using ICTs as deemed appropriate.

IPRC is planning the following incentives: Webinar and distance learning classes will be free and programs to be required to use online system or complete online evaluations in order to receive reimbursement.

Making available use of technology for communication, training, and meetings to improve time efficiency and reduce travel costs to participate in state level meetings

d. What support system does the State plan to provide to encourage their use?

The IPRC is planning the following: Available computer technology specialist for phone consultation, video outline instructions on how to use the technology, utilize free services and easy use programs that people will already have installed on computers (won't require a software purchase)

e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?

DMHA will conduct ICTs needs assessment to determine where technology needs exist and develop strategies to address needs. Partnerships among provider as well as seeking out funding for technology development may be some of the options considered for future planning and development.

IPRC barriers to use identified are: restrictions on use, such as state government can't use Skype, varying levels of IT IQ, Out of date hardware (unable to support systems), and satellite internet can't handle/ too slow.

f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

DMHA leadership is a member of a statewide collaboration involving FQHC/CHC/RHC, CMHCs, Managed care organizations, OMPP, DMHA ICCMHC, IPHCA, ISDH, and HRSA. Use of ICTs is one of many issues the group is tackling in its quest to further develop and implement integrated care models across Indiana. The collaboration has five cross-agency subcommittees to address challenges and barriers related to use of technology and data. Real time communications, EHR, HIT, and data sharing via technology are some of the priority areas the subcommittee is addressing.

IPRC is adding mental health data to their prevention statistics program that will allow communities to utilize mental health statistics when conducting needs assessments and program planning. Data are already available for a wide range of other information including drug use, gambling behaviors, crime, and protective factors such as schools and religious institutions

- g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?*

IPRC already utilizes technology for evaluation programs. This includes gambling trainings and events, grants, Community That Care (CTC), afternoon ROCKS in Indiana, and the Strategic Prevention Framework (SPF).

Currently Access to Recovery and Problem Gambling activities are utilizing a web-based system (WITS) to collect data and pay claims. The data collected through WITS is used to evaluate program service and funding utilization at a client and provider level. These are the only programs within DMHA that connect funding to a specific consumer and their services.

- h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?*

IPRC uses surveys after webinars asking about quality of audio/video and if participants would take another webinar or use a distance learning format on this topic again. IPRC also conducts internal cost-effectiveness analysis (paper vs. online).

SurveyMonkey is frequently used to gather baseline data and repeated surveys to monitor change. This use of technology is the primary strategy for the primary and behavioral health care integration initiative to assess cross-systems activities and practice.

A help desk (web-based) is in place to accept, monitor and track issues/resolution within current ICT data collection systems.

U. Technical Assistance Needs

Block Grant Application Instructions: *States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.*

1. What areas of technical assistance is the state currently receiving?

The Indiana Division of Mental Health and Addiction (DMHA) has utilized technical assistance from federal entities as well as other states and agencies frequently over the past year as the state prevention system continues to be restructured. The Center for the Application of Prevention Technologies (CAPT) has been instrumental in providing valuable technical assistance services to Indiana during our system redesign. CAPT has been utilized to assist Indiana in bringing the Strategic Prevention Framework to scale statewide through capacity building and infrastructure development of the state behavioral health and prevention workforce. In 2012, CAPT assisted Indiana in creating a comprehensive workforce training calendar and trained state staff and the state-contracted technical assistance provider in the new Substance Abuse Prevention Skills Training (SAPST). As a result of the training, Indiana was able to have three individuals in the state trained to deliver the SAPST, allowing the state to use its own trainers with CAPT assistance to train new grantees in the SAPST. In 2013, DMHA utilized CAPT resources to expand the state's capacity as well as its ability to provide quality technical assistance services to its Block Grant sub-recipients. CAPT services included consultation on the development of an evidence-based practices workgroup; training the state contracted technical assistance providers and state staff in environmental strategies including selecting, evaluating, and providing technical assistance to communities on environmental strategies; development of a basic environmental strategies training for funded communities; and consultation in the design of fidelity tools.

As a 2013 participant in the SAMHSA Service Members, Veterans, and Their Families Policy Academy, DMHA has received technical assistance in collaborating with stakeholders across the state to develop and strengthen initiatives for this population. This has included

assistance in identifying the needs and strengths in state systems related to this population; identifying goals related to needs and strengths; and developing and strengthening a coalition to focus on these efforts. The Indiana coalition formed through the policy academy intends to utilize the SAMHSA Service Members, Veterans, and Their Families Technical Assistance Center web portal in future planning and collaboration as well.

2. *What are the sources of technical assistance?*

For prevention purposes, DMHA has primarily utilized assistance from the Center for the Application of Prevention Technologies (CAPT). DMHA has also reached out to the National Prevention Network (NPN) representatives in other states primarily in the Central region including Illinois, Ohio, and Wisconsin to assess the policies, practices, and service delivery, data collection, and evaluation models in other states. Indiana has begun an in-depth peer sharing consultation with the state of Illinois (IL), bringing contractors from the Center for Prevention Research and Development (IL), Prevention First (IL), and the Indiana Prevention Resource Center (IN), as well as the NPN representatives of both states, together to discuss bringing the strategic prevention framework model to scale statewide as well as improving the quality of data collected by each state's respective youth survey.

3. *What technical assistance is most needed by state staff?*

Indiana DMHA is most in need of technical assistance in the areas of developing the prevention workforce; identifying alternative funding for the Access to Recovery grant program; developing initiatives focused on military service members; and adapting to changes related to the Affordable Care Act and the integration of primary and behavioral health care in Indiana.

Related to prevention, DMHA is in need of technical assistance to further develop the capacity of the state prevention workforce including the development of a training series to infuse prevention basics to coalitions, non-profits, and other prevention providers statewide. Indiana is in the preliminary stages of addressing this need through consultation with CAPT and through partnerships with the Indiana Criminal Justice Institute. It is apparent that many providers statewide are lacking the basic prevention fundamentals necessary to ensure successful outcomes are achieved at the local level. The state will seek assistance to design trainings to build the capacity of local level providers to increase their prevention knowledge as well as other necessary tools to ensure desired outcomes in their communities.

Secondly, DMHA would benefit through technical assistance regarding the continuation and expansion of the Access to Recovery (ATR) program. DMHA received SAMHSA awards for ATR II in 2007 and ATR III in 2010, and has expanded ATR to 11 counties and to service

members and veterans statewide. This represents approximately 47% of Indiana's population of persons age 18 and over. However, ATR federal funding will end September 30, 2014. Technical assistance for obtaining alternative funding as well as for expanding ATR to become statewide would be beneficial.

A third technical assistance need is related to initiatives for military service members, veterans, and their families. DMHA is presently involved in several projects targeting the military and military families, including the STAR Behavioral Network, which provides training in military culture to behavioral health providers, and participation in the SAMHSA Service Members, Veterans and Their Families Policy Academy. However, Indiana is still in the early planning steps of adequately addressing the needs of this population and would welcome additional technical assistance to continue moving forward.

Finally, Indiana is in need of technical assistance related to changes resulting from the Affordable Care Act (ACA) as well as the integration of primary and behavioral health care. While it is difficult to determine specific needs since Indiana has not yet identified how it will incorporate ACA statewide, it would be beneficial to have technical assistance regarding best practices for integration as well as the integration of health records. In the absence of Medicaid expansion in Indiana at the time of this writing, DMHA would also benefit from technical assistance on Substance Abuse Block Grant funding of treatment and recovery support services.

4. *What technical assistance is most needed by behavioral health providers?*

Behavioral health providers in Indiana are most in need of technical assistance regarding adherence to the Affordable Care Act (ACA) requirements; however, this is somewhat difficult to provide as Indiana has yet to identify how it will incorporate ACA statewide. Along with this, behavioral health providers would benefit from technical assistance in the move toward integration of primary and behavioral health care in the areas of best practices guidelines, integrated health records, and funding mechanisms.

V. Support of State Partners

Block Grant Application Instructions: *The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information exchanges (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ this could include, but is not limited to:*

- *The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.*
- *The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.*
- *The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.*
- *The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.*

- *The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.*

All of the following agencies have current representation on the Mental Health and Addiction Planning and Advisory Council (MHAPAC) and/or are engaged with DMHA in cross-agency partnerships.

1. ***The State Medicaid Agency** agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.*

The Division of Mental Health and Addiction's (DMHA) projects and initiatives with the State Medicaid Agency include but are not limited to the following:

- Explore, develop, and collaborate on initiatives to support and promote integration of behavioral and physical health including but not limited to health homes models.
- The Office of Medicaid Policy and Planning (OMPP) is currently represented on the State Epidemiological Outcomes Workgroup, contributing valuable data and input to shape state prevention priorities.
- Development of 1915i State Plan Amendments for ongoing habilitative services
- Submission of two 1915i State Plan Amendments based upon success of Medicaid Rehabilitation Option (for adults with Serious Mental Illness) and the Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) demonstration project (for youth with Serious Emotional Disturbance).
- Consultation and collaboration on the benefits available to the expanded Medicaid population.
- Implementation of a PRTF waiver, as a component of CA-PRTF sustainability.
- Coordination of grant project implementation for a State Medicaid Agency Centers for Medicare and Medicaid Services (CMS) grant award related to housing and homelessness.

2. ***The state justice system** authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.*

Partnership projects and initiatives with the state justice system include but are not limited to the following:

- The DMHA/Indiana Department of Correction (IDOC)/Advocates Workgroup meets on a bi-monthly basis acting as forum regarding the management of offenders with serious mental illness. The primary goals of the workgroup are communication and problem-solving. A primary accomplishment to date has been the MOU with Family Social Services Administration, the State Medicaid Agency, and IDOC. The purpose of the MOU was to identify offenders that may qualify for assistance programs and complete all paperwork prior to release for the Supplemental Nutrition Assistance Program (food assistance), Temporary Assistance for Needy Families, and Medicaid as well as schedule appointments at the appropriate times, participate in interviews as needed, and oversee the application process.
 - IDOC now has 2,000 Therapeutic Community beds, with a long-term goal of 2,800 beds. Services at Madison Correctional Facility (for women) have expanded with the addition of a Therapeutic Community as of July 1, 2012. A Therapeutic Community is a substance abuse treatment program that takes an average of nine months for an offender to complete. Completion leads to a cut in time, which in turn has saved IDOC the equivalent of 1,200 beds.
 - DMHA has a contract with IDOC to complete the SOGS (South Oaks Gambling Screen) at intake on everyone in the Therapeutic Communities. Individuals who receive a score indicating they have a gambling problem receive education and community referral information for problem gambling services upon their release. Data on SOGS scores are received on a quarterly basis.
 - Mental health assessments have been added to the process of intake evaluation at the Indiana Reception Diagnostic Center (RDC).
 - The IDOC is represented on the State Epidemiological Outcomes Workgroup and has played a vital role in sharing data related to the substance abuse rates and mental health needs of the incarcerated and reentry population. The SEOW is currently working with data provided by IDOC to produce a special report supplement on this population.
 - DMHA and IDOC have partnered on multiple federal grant opportunities related to coordination of care, re-entry, and diversion.
3. *The **state education agency** examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.*

Partnership projects and initiatives include but are not limited to the following:

- The Indiana Department of Education (DOE) participated in the Suicide Prevention Advisory Committee and was an integral part in drafting the *Indiana State Suicide Prevention Plan* as well as recommending policies to support the plan such as the completion of suicide prevention training as a prerequisite for teaching licensure, stronger school policies on bullying and violence, and increased reporting and classification of in-school discipline problems as a risk screening tool.
- The Prevention Workgroup Committee has expressed the need for representation from DOE and is currently seeking additional members to serve as advisors on evidence-based prevention programs as well as promote the use of the Indiana Youth Alcohol, Tobacco, and other Drugs Survey as a planning tool for prevention services among Indiana schools.

4. *The **state child welfare/human services department**, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.*

DMHA's projects and initiatives with the state child welfare/human service department, the Department of Child Services (DCS), include but are not limited to the following:

- DCS participates on a multidisciplinary team to review and staff families that have difficulty accessing needed and appropriate services. This team meets every two weeks and includes DCS, Bureau of Developmental Disabilities and DMHA representation.
- Partnership between DCS and DMHA to roll out the DCS Children's Mental Health Initiative that allows families to access needed and appropriate mental health services without entering the DCS system. This project started in November 2012 and is active in 11 counties with goal of being statewide by the end of 2013 calendar year. DCS is utilizing the access sites that were developed by DMHA for the Community Alternatives to Psychiatric Residential Treatment Facilities demonstration grant.
- DMHA partnered with DCS and the National Alliance on Mental Illness of Indiana to apply for the SAMHSA System of Care Expansion Planning Grant.
- DCS is an active participant on the Children's Mental Health Advisory board as well as the System of Care Subcommittee.

5. *The **state public health authority** that provides epidemiology data and/or provides or leads prevention services and activities.*

DMHA will continue to partner with the Indiana State Department of Health (ISDH) and other stakeholders to collaborate in the promotion and facilitation of integrated behavioral and primary health care leading to a specialty endorsement or certification for integrated care providers. Joint projects and initiatives include but are not limited to the following:

- Through a partnership with ISDH, DMHA is revising the Certified Recovery Specialist (CRS) training materials. The revised training is whole health focused and centers on integration of formal peer support in primary and behavioral health care. These efforts include a formal partnership with ISDH to establish a single State authorized training that will adequately prepare persons to provide peer support in all health care environments. It is believed integration of the peer workforce will ensure greater success for the system as a whole as it integrates care philosophies and services.
- ISDH played an integral role in the development of the *Indiana State Suicide Prevention Plan* and representatives currently serve on the Suicide Prevention Advisory Committee.
- ISDH is an active member of the State Epidemiological Outcomes Workgroup and contributes a wealth of data to the annual state epidemiological profile.
- Explore, develop, and collaborate on initiatives to support and promote integration of behavioral and physical health including but not limited to health homes models.
- DMHA will work in conjunction with ISDH and the State Medicaid Agency to develop integration standards and best practices guidelines to implement across the state.
- Coordinate linkage and development of partnerships for integration.
- Collaborate to develop curriculum for cross-training Community Health Workers and Certified Recovery Specialists.
- Provide support and technical assistance in development standards and expectations as well as methods to assess and monitor outcomes of integrated practices. Participate in implementation of the Project LAUNCH Grant awarded to ISDH

6. *The state housing authority: DMHA collaborates closely with the Indiana Housing and Community Development Agency (IHCDA) and Corporation for Supportive Housing (CSH). Projects and initiatives include but are not limited to the following:*

- Coordination of grant project implementation with IHCDA and the State Medicaid Agency for the Centers for Medicare and Medicaid Services Real Choice Systems Change Grant award related to housing and homelessness.
- Development and implementation of Notice of Funding Availability grant application to provide Section 811 supportive housing vouchers to improve access and increase the number of safe, affordable housing options for individuals coming out of institutional settings.
- Collaboration with IHCDA and CSH to facilitate the development and implementation of an annual Supportive Housing Institute aimed at bringing housing and behavioral health

providers together in their communities to build additional supportive housing opportunities for individuals with behavioral health issues.

W. State Behavioral Health Advisory Council

Block Grant Application Instructions: Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. SAMHSA encourages states to expand and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

What planning mechanism does the state use to plan and implement substance abuse services?

- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

- *Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.*

1. *What planning mechanism does the state use to plan and implement substance abuse services?*

The Division of Mental Health and Addiction (DMHA) examined the roles and functions of several advisory and planning councils, and these official and unofficial groups were merged into one planning and advisory council in 2011 that now exists under Indiana Code. The planning council includes substance abuse and mental health services. The substance abuse treatment planner and the substance abuse prevention planner attend and present at planning council meetings. The new Mental Health and Addiction Planning and Advisory Council (MHAPAC) meets all of the requirements of the Block Grant planning council membership. Additionally, this council has greater access to the director of DMHA and is involved in a wider range of planning than the previous Block Grant planning council.

2. *How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?*

They are one and the same. The planning council is representative of mental health and substance abuse including treatment and prevention services. Individuals on staff responsible for substance abuse prevention and treatment attend each planning council meeting.

3. *Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.*

In SFY 2012, DMHA implemented a practice that actively involved planning council membership as never before. Members of the planning council are involved in the workgroups for each of the Block Grant priority areas. This places the membership in frequent contact with DMHA staff and in the planning and implementation of the plan process. The members of the planning council have presented for the priority area workgroups instead of relying on DMHA staff in reporting on those activities to the full planning council. This has further emphasized the “hands-on” work the planning council has done under this new design. A survey of the planning council members involved in the priority area workgroups resulted in the following comments:

“I think it is important that planning council members participate in the workgroups-that is where the majority of the work happens. I appreciate that there is consumer involvement in state planning for the block grant and overall direction for Indiana.” Jill Matheny-Fuqua, planning council member

“I have found the planning council very informative and educational. I feel like I'm actually helping put focus on those persons with mental health or addictions, and hopefully influence and guide where the DMHA puts their efforts. By contributing my ideas and thoughts I feel that the Planning Groups are necessary as a tool to reach out to the mental health community. By presenting the information gathered and assimilated I believe the awareness of the status of mental health care today will be greatly enhanced.” John Wilford, planning council member

“NAMI Indiana constituents are well-served by DMHA's inclusion of our statewide organization in its planning efforts. In the areas of housing, recovery supports, and integrated care, we have been empowered to share a vision of mental health consumers, their support partners, and their providers coming together to form catalysts for recovery from serious mental illnesses. We have also been heard. By inviting NAMI Indiana leaders and members into its regular planning workgroups as full members, it provides healthy and innovative opportunities for collaboration and partnership. Often, some of the best insight and ideas on complex policy issues come from consumer peers, family members, and providers in the trenches. DMHA gets that, and is wise to continue and increase its practice to strategically gather and incorporate that feedback to affect outcomes in our communities.” Joshua Sprunger, Interim Director, NAMI, Indiana, planning council member

4. *Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?*

Yes. The membership of the planning council includes representatives of substance abuse treatment and prevention. The Division of Mental Health and Addiction includes the substance abuse planner and the prevention planner, both attend and present at the planning council meetings. Issues of co-occurring disorders are addressed by both the substance abuse staff and the mental health staff.

5. *Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?*
- a. The planning council membership conforms to requirements of the Block Grant. Efforts have been focused on bringing together membership that represents diversity in race, ethnicity, gender, rural/urban and spans across the lifespan. Membership is also focused on having non-state employee representatives with backgrounds in the addiction, mental health, and treatment and prevention arenas. Consumer and family members across all populations are sought out to participate in the planning council.

- b. *Does the membership reflect the demographics of the service area population in the state?* No.
- c. *Is it diverse?* Yes. The planning council includes representation of services providers, SA, SED, and MI, and it includes consumers of MI and SA services. DMHA has made efforts to assure a geographic mix in the membership and there are three members that are from rural counties. There are five that have a children's focus.

6. *Please describe the duties and responsibilities of the Council.*

The attached planning council charter provides the overview of their responsibilities and it also shows the formalization of the body. It should be noted that the planning council has a greater scope than the Block Grant requires, as it is advisory to DMHA in all aspects of its operation.

The PDF file of the MHAPAC Bylaws can be uploaded online.

X. Enrollment and provider business practices, including Billing Systems

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- *Outreach and enrollment support for individuals in need of behavioral health services.*
- *Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.*
- *Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.*
- *Third-party contract negotiation.*
- *Coordination of benefits among multiple funding sources.*
- *Adoption of health information technology that meets meaningful use standards.*

At the time of this writing, DMHA is unsure of Medicaid coverage or of what changes will occur in Indiana as a result of the Affordable Care Act. Therefore, how the three percent will be set aside and utilized is not able to be determined at this time.

Y. Comment on State BG Plan

Please enter any comments here to be collectively summarized and added.